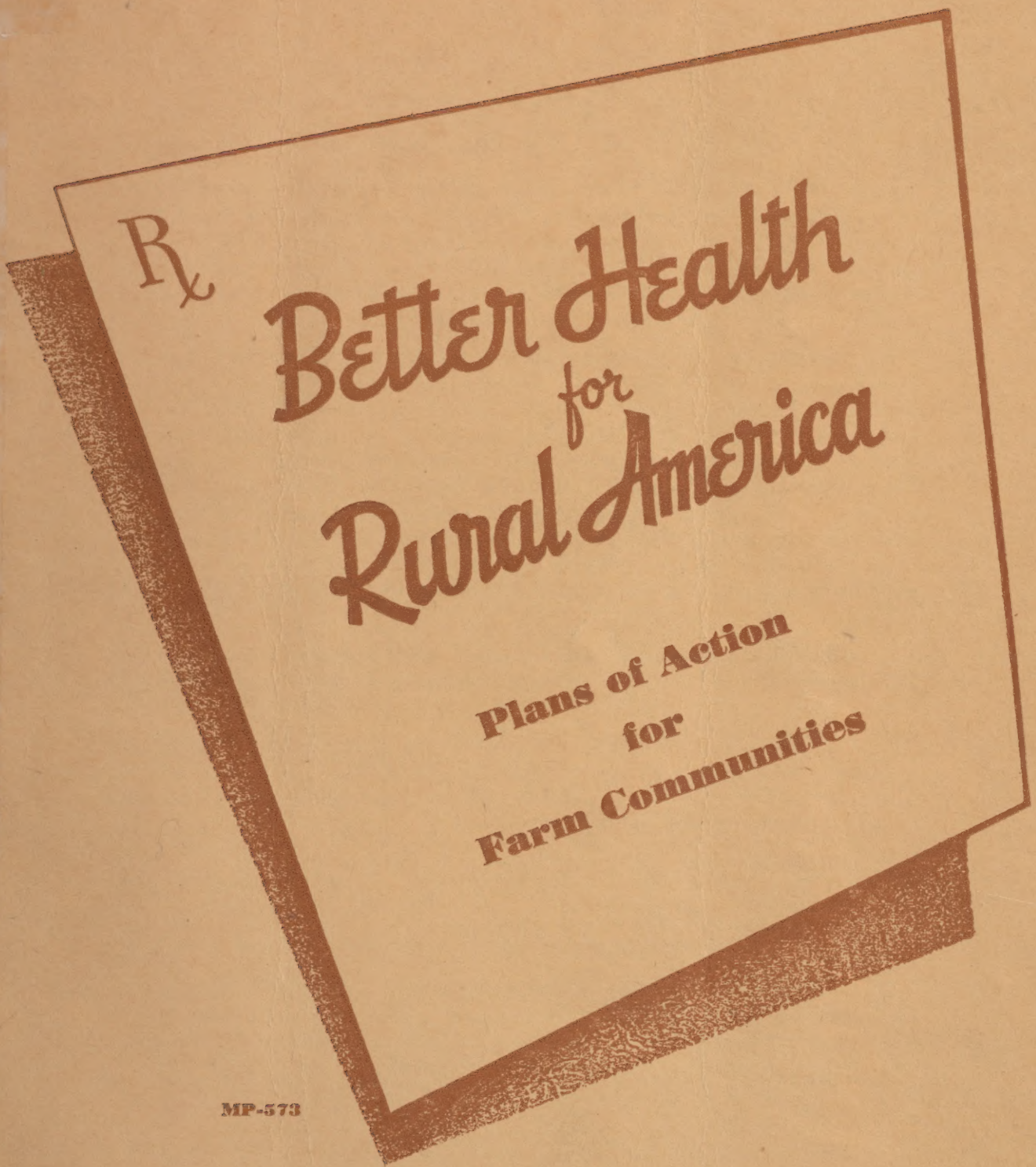

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UNITED STATES DEPARTMENT OF AGRICULTURE
INTERBUREAU COMMITTEE ON POST-WAR PROGRAMS

Washington, D. C. October 1945

FARMERS WANT BETTER HEALTH

THIS DISCUSSION of the main problems of rural health services and what can be done about them is a presentation of the Department of Agriculture's Interbureau Committee on Post-War Programs. It has been prepared by a working group under the direction of F. D. Mott, M.D., of the U. S. Public Health Service, who is the National Activity Leader in Rural Health and Sanitation of the United States Department of Agriculture Interbureau Committee.

Members of the working group include Milton I. Roemer, M.D. of the U. S. Public Health Service, assigned to the Farm Security Administration, Lucile Reynolds of the Federal Extension Service, Grace M. Angle of the Bureau of Human Nutrition and Home Economics, M. R. Hanger of the Bureau of Agricultural Economics, Kenneth E. Pohlmann and Eleanor Doak of the Farm Security Administration, Henry B. Makover, M.D., of the U. S. Public Health Service, assigned to the Office of Labor, Harry J. Becker of the Children's Bureau, and Margaret C. Klem of the Social Security Board. Cooperation and advice were received from a number of other health and education workers in these and other agencies in the Federal Government as well as in governmental and voluntary groups in nearly all of the 48 States.

Rural health is a living subject and the facts about it change from day to day. It is hoped that new knowledge and new ideas submitted by persons interested in rural health from all over the Nation will help in the preparation of new materials on this subject, as we move ahead toward our goal of better health for rural America.

Farm people are deeply concerned about their health and their medical services. There are many groups planning and many different ideas, but farm people are more or less agreed on what they want.

1. **They want more doctors, nurses, and dentists in their communities.**
2. **They want more hospitals and better sanitary facilities.**
3. **They want more preventive medicine and public health clinics.**
4. **They want easier ways of paying their doctor bills.**
5. **They want all the benefits of first-class medical science that they read about.**

What are some of the reasons that farm people have these wants? What are the health problems about which they are concerned? What has already been done to tackle these problems? What can farm people do now to solve them? This publication may be of assistance in answering these and related questions.

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★ BETTER HEALTH FOR RURAL AMERICA ★

THE FACTS ABOUT RURAL HEALTH AND MEDICAL CARE

Farm people all over are beginning to realize that all is not perfect with rural health.

There have been a lot of mistaken notions about what a healthy place the country is to live in. Maybe 50 or 100 years ago the rural areas were "God's country" compared with the congested and filth-ridden cities. But things have changed. While great improvements in health have been enjoyed in the cities through sanitation, better housing, and the benefits of medical science, progress in the country has been relatively slow.

Food and Shelter Come First

Now, there are many general things that affect the health of people such as their nutrition, their educational level, their housing conditions, and general economic circumstances. All the medicine in the world isn't going to keep a family in good health if they live in a damp and drafty old house or get along on a diet of pork and beans. Though most farm people understand this, they are becoming increasingly concerned about the more specific needs for medical care.

Small-Town Health

Actually, the health situation in the open country does not seem to be as bad as it is in the small towns. A large part of America's 57 million rural people live in communities of under 2,500 population. In these hamlets and villages and in small towns up to about 10,000 people, some of the natural benefits of farm life—plenty of sunshine and fresh air, vigorous exercise, garden-fresh food, and freedom from congested living—have been lost and yet the modern scientific advantages of the big cities have not been gained.

Still the whole problem of improving health services for country people is the same for the small towns and villages as for the open country. The doctor or the hospital located in a small trade center, after all, has to serve the families in the open farm country for miles around. Even the big cities ought to be concerned about rural health because city populations are made up largely from people who have left the farms.

THE BURDEN OF ILLNESS AND DEATH

While the general death rate of rural people is today still slightly less than that of city people, the decline in death rates has been much less in the country than in the cities. In 1900, the American farmer could claim a death rate about 50 percent below that of his city cousins. Today he can claim hardly a 10-percent advantage. In fact the present death rate among our infants and small children, who should be the best protected part of our entire population, is actually higher in rural areas and small towns than in large cities.

Preventable Deaths

Deaths from the very diseases that modern science and sanitation are best able to prevent are highest in the rural areas. For typhoid and paratyphoid fever, for example, or for diphtheria, or for malaria or pellagra—diseases which are often considered practically conquered—the rural death rates are much higher than the urban. Pneumonia, despite the wonderful new sulpha drugs and penicillin, takes a higher toll in the rural areas and small towns than in the larger cities. If the experience of the best-off sections of the Nation were enjoyed in every State, then in the rural State of North Carolina, for example, some 16,000 premature deaths could be prevented each year.

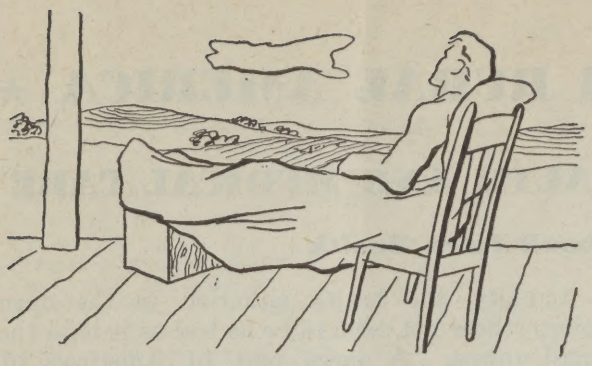
Maternal mortality (deaths of mothers in connection with childbirth) was almost one-third higher in rural communities than in large cities in 1941. And in 1942 the infant mortality (death rate of babies under 1 year)—generally believed to be the most sensitive sign of a people's welfare—was over one-fourth higher in rural sections than in large cities.

Farm Accidents

Agricultural work is far more hazardous than most folks realize. In 1943, 4,500 persons working in agriculture were killed on their jobs; this accounted for 25 percent of all persons killed at work in that year, although persons engaged in agriculture represent only 16 percent of all working people. This rate—54 deaths by accident per 100,000 workers—while not the highest among all occupations, exceeded, for example, the rate of 20 deaths per 100,000 workers in manufacturing industries. In addition, tens of thousands of farm people are injured or permanently disabled each year from accidents that could have been avoided.

Disease and Disability

As for the general occurrence of illness—the common cold, the intestinal disturbances, the headaches, the joint pains, and so forth—it causes



its miseries day after day. Taking into account that the farmer tends to be rather quiet about his suffering and does not readily report illnesses to health investigators, it would seem that the rural family has about the same amount of sickness as the city family, or possibly more. It comes to an average of about 4 or 5 cases of illness in every farm family each year—and that doesn't count many little injuries or colds that don't lay us up. The chronic illnesses, which make a slow drain on a person's energies or lay him up for several weeks at a time and exhaust his finances, perhaps cause the most distress. Many a farm failure can be traced to a bad back or an untreated heart condition.

Physical Defects

Recurring illness not properly attended by doctors is bound to result in a high occurrence of chronic physical defects. These defects, in turn, often lead to new attacks of sickness. Studies by the Farm Security Administration involving thousands of low-income farm people in seventeen States, showed between 3 and 4 significant defects per person. Fourteen percent of the men and women, for example, had varicose veins. One farm operator out of every 12 had a hernia. Nineteen percent had hemorrhoids, and 42 percent of the wives, in the white families alone, had internal tears due to childbirth. Many had defective vision not corrected by glasses or had badly infected tonsils. There were far too many underweight and malnourished children. Serious conditions of the teeth occurred in practically everyone. How these conditions must affect a farm family's ability to produce is obvious.

Hidden Hungers, Nervous Disorders

In addition to physical defects like these, there are tens of thousands of rural people suffering from diseases like malaria, hookworm infestation, and pellagra or other forms of hidden hunger, which can be detected only by careful laboratory studies. Poor soils—eroded, poorly fertilized, with improper crop rotation—often yield poor food, low in nutritive value. Even though they live on the land, many farm people's diets are so poor that there must be a great deal of malnutrition that just wears a person down from day to day, without appearing like acute illness.

There are many other ailments, which the doctors call functional, that do not give any concrete signs but still cause people untold misery. Among these are the serious psychoneuroses, or mental disorders, most of which went unrecognized until the war came along and millions of young men were given careful physical and mental examinations.

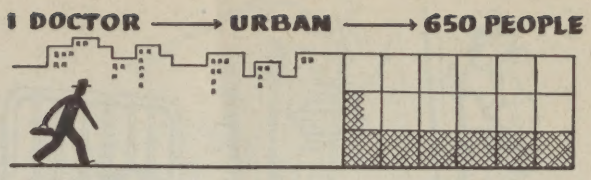
Millions of 4-F's

Everyone has been startled about the millions of American young men rejected for the armed forces because they didn't measure up to military standards. Farm people should be more distressed than others because farm youth showed considerably higher rejection rates than the average. Among 9,000,000 draftees examined, 43 out of every 100 were rejected, but among those coming from farms 53 out of every 100 were turned down. This is the opposite of the situation in the last war, so the health of rural youth is relatively going downhill.

Many of the rural rejections have been due to lack of education associated with poor country schools in areas of rural poverty. Even these rejections may often be due to poor health (sickly children don't do their lessons well), but more important, even if there had been no rejections for lack of education, farm youth would have been rejected for physical defects alone at a rate of 41 out of every hundred, compared with 38 out of a hundred for the average. Studies show that many of these rejections could have been prevented by proper care in childhood. Thus, despite the advantages they have had in vigorous, outdoor living, many thousands of farm boys have been found unfit for military service.

TOO FEW DOCTORS AND DENTISTS AND OTHER HEALTH WORKERS

All of these problems are closely tied up with the lack of enough well-trained doctors and dentists and other health workers in rural communities. The rural areas have always suffered from a shortage of technical people, but in the last 25 or 30 years the situation has certainly grown worse. The old-time country doctor with his black bag and his horse and buggy did a heroic job for which we all have admiration, but today he is fighting a losing battle. His forces are not being adequately replenished by young, well-trained graduates from the modern medical schools. Almost half of all young doctors nowadays come from medical schools in five industrialized States while 18 States, mostly rural, turn out no medical graduates from schools within their borders. These younger graduates tend to settle in the cities where they feel, with good reason, that they can make a better living and, at the same time, have access to the modern hospitals, technical equipment, and professional contacts which they need in order to do a good job.



"Is There a Doctor in the County?"

When we consider all the time it takes for a rural doctor to travel about the countryside seeing patients, a ratio of about one physician to 1,000 people, or even fewer, is probably necessary, if rural people are to enjoy a true parity of physicians' services with city people. Yet, in the thousand most rural and isolated counties just before the war, there were so few doctors that each one had to serve 1,700 people, while in the big city areas there was a doctor for each 650 people. What's more, many country doctors are getting well along in years and often through no fault of their own many find it hard to keep up with advances in medical science.

Off to the Army

Since the war, the shortage of rural practitioners has become more alarming. Our rural doctors almost everywhere exceeded their quotas in entering the armed forces. As a bare wartime minimum, it has been said that there should be at least 1 physician to every 1,500 persons in the community. Yet in hundreds of rural counties ratios of one physician to 3,000 or 5,000 or even 10,000 people have come about as a result of the war. What's worse, as things stand now, there is no guarantee that even those doctors and dentists who had been in the rural areas will return to them now that the war is over—unless something positive is done about it.

Too Few Dentists

The shortage of dentists is even worse, although the teeth of nearly all people—rural and urban alike—are in need of dental work today and year after year. Although there probably ought to be 1 dentist for not more than every 1,500 people, most rural areas have hardly a third of this ratio. Before the war, there was 1 dentist to every 1,400 persons in the cities but only 1 to every 4,200 in the rural sections.

Hardly Any Specialists

A fairly capable surgeon may be located within reach of most rural people, but other specialists in fields such as the eyes, the nervous system, the kidney system, the care of children, or X-ray work, so common in the cities, are practically unknown in widespread rural areas. This wouldn't be so bad if farm people with serious ailments requiring specialists could be easily referred to them, but this is seldom done. Not only is the rural patient usually unable to afford the consultation of a specialist, but his country doctor is seldom in close professional contact with specialists to whom the patient might be referred.

Not Enough Nurses

Even though a good nurse, in some degree, can make up for the lack of a doctor, the supply of nurses in the country is just as poor as the supply of doctors. The war has made matters worse, but even in 1940 the rural State of Mississippi had only 62 active nurses per 100,000 people, while industrial Massachusetts had 403. Many rural hospitals do not have even one graduate nurse, although "practical nurses" often do a good job of pinch hitting. There aren't many nurses for "private duty" work in the home either. As for public health nurses or visiting nurses, their numbers are far below the needs of rural families. The general shortage of rural nurses is largely related to the dearth of good hospital facilities in rural districts.

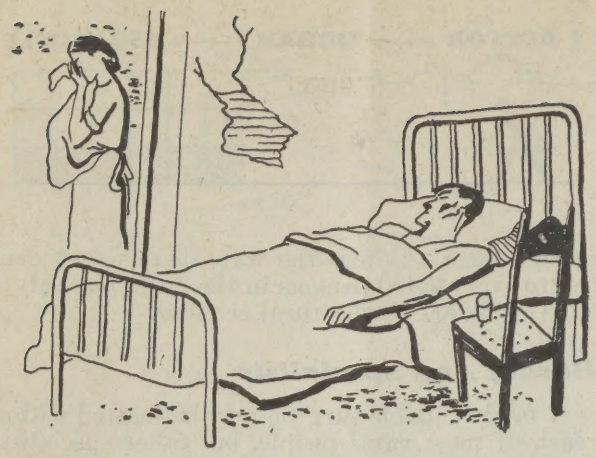
Because of the rural shortage of well-trained professional persons, thousands of rural people must depend for their medical services largely on untrained midwives, drug-store clerks, or cultists.

THE LACK OF HOSPITALS AND OTHER FACILITIES

Widespread rural areas are very poorly served by hospital facilities. Over 1,250 of the 3,070 counties in our Nation are without a single satisfactory general hospital. Over 700 of these counties have populations exceeding 10,000 people.

Far Below the Needs

To serve people properly there ought to be about 4.5 general hospital beds for every 1,000 persons in a State. Quite a few cases of illness among rural people, however, are and should be referred to city hospitals for care. While in the cities, therefore, 5.0 or more beds per 1,000 persons may be necessary, in the rural areas 3.5 or 4.0 general beds per 1,000 are probably adequate. The fact is that today most rural areas do not have even 2.0 beds per 1,000. Besides the hundreds of counties with no satisfactory hospital at all, there are 450 counties in which the only general hospital is a proprietary institution (op-



erated for profit) and in these counties the average ratio is only 1.5 beds per 1,000 people.

Not only are there fewer beds per thousand people, but country hospitals tend to be smaller and less well equipped with modern diagnostic and treatment apparatus. They usually lack the "out-patient department" or clinics of the city hospital for patients not requiring bed care.

Low Occupancy

This doesn't mean that we should immediately set out to build hundreds of rural hospitals without doing other things at the same time, for the disturbing part of it is that many of the rural hospitals we now have are usually far from fully occupied. It is no surprise that in many rural areas people still look on the hospital as a place to die. Because of economic and other barriers, they haven't had much experience with good, well-staffed modern institutions in which most people recover and even enjoy their hospital stay. Practically speaking, the crucial question is not so much how many hospital beds do rural people actually need, but how many can they pay for. Our task is to work out ways to help them pay for all those that they need.

Private Management

A large portion of rural hospitals are owned by private individuals, most often by doctors. Their establishment by these men has been a real public service but such hospitals have their bad side. For one thing, "free" beds are seldom maintained for people who cannot pay for care. Because of private ownership, moreover, the medical staff is often "closed" so that some qualified doctors in the area may not be allowed to treat their own patients in the only hospital at hand. In the cities it was long ago learned that people can be served best if hospitals are run by the entire community, through the local government, or by nonprofit associations like churches or other groups.

Not Enough Sanatoriums

Regarding hospital beds for tuberculosis or for mental disease—conditions which have been generally accepted as public responsibilities—the situation is even worse. Medical authorities point out that there ought to be 2.5 beds for tuberculosis for every TB death occurring in the State each year. Yet in the 28 States that are over half rural there are only 0.9 TB beds for every death occurring from this disease, compared with a ratio of 1.8 beds per death in the 20 most urban States. Thousands of rural people today are left to die at home with their "consumption" and, what's worse, are free to spread the infection to those around them, simply because they cannot be properly isolated in small rural dwellings.

How many "queer" folks in rural communities are cases of untreated mental disorder is anybody's guess. The fact is that these people are seen about the villages or found hidden away in their homes, mainly because there are not enough modern mental hospital beds in which to care for them or mental hygiene clinics in which to treat them. Authorities claim 5 beds per 1,000 persons ought to be supplied to care for cases of mental disorder, but the predominantly rural States have only 3.4 beds per 1,000, compared with 5.6 beds per 1,000 in the most urban States. The hospitals for convalescent care or for treating special conditions found in the cities are practically never found in rural sections.

Few Clinics and Laboratories

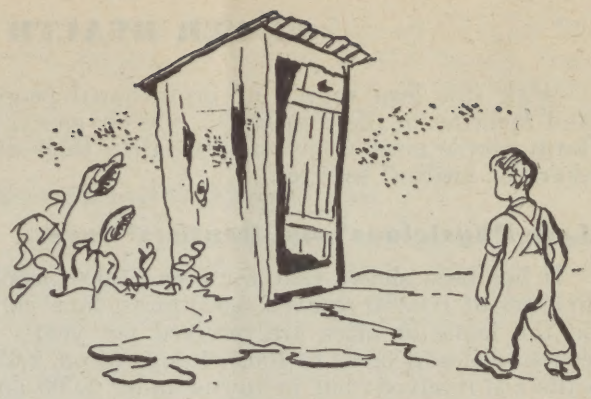
Public clinics or "health centers," where people can come for diagnosis or treatment without necessarily being hospitalized, are practically unknown in rural areas today. Scientific laboratory facilities and well-trained technicians for helping the doctor to diagnose disease are scarce indeed. Yet the diagnosis of disease in early stages, when it is most readily cured, depends often upon the delicate sensitivity of laboratory tests which the eyes or ears or fingertips of even the most skilled physician cannot equal. It may be said that the village drugstore or the general store with its big patent medicine counter is the most familiar "health center" in many country districts.

POOR SANITATION

Many serious diseases come from poor water supplies or improper facilities for disposing of human and household wastes. Yet studies have shown that three out of every four rural families in this country are without proper sanitary facilities. Of the two-thirds of American rural families who in 1940 used outdoor privies, more than half needed their privies improved or completely replaced to put them in a sanitary condition. One farm family in 16 has no privy or toilet at all! One out of every eight farm families has to get its water from a source more than

50 feet from the house. In fact, the great majority of the water supplies lack sanitary pumps and proper protection against surface contamination. Numerous rural homes lack the screening necessary to help keep out disease-carrying flies and mosquitoes. Refrigeration for proper preservation of foods is rare. Since the war rural sanitary facilities have become further run down and have not been repaired because of the shortage of materials and labor.

A lot of rural people "get along" with their poor sanitation facilities. They are not conscious of how much they suffer from them either by way of filth-borne diseases or by the generally deteriorating effect of careless living on a person's morale.



WEAK PUBLIC HEALTH AND PUBLIC WELFARE PROGRAMS

In order to stop disease before it starts, it is necessary to have strong and effective organization of public health work. Such a program should and can promote good sanitation, farm safety, the prevention and control of acute communicable diseases or venereal infection or tuberculosis, the care of expectant mothers and of infants, the protection of children in and out of school, the improvement of nutrition, the education of all people about healthful living.

Yet in 1941 almost 1,400 of America's 3,070 counties were without the services of a full-time department of public health and practically all of these were rural counties. War conditions made the situation even worse.

Health Departments Understaffed

Many of the county health departments that we do have are very weak—with barely the recommended minimum staff of a physician, a sanitary officer, a clerk, and one or two nurses. Actually there are far too few rural health departments with staffs really adequate to do the job. The so-called "part-time" health officers found in many rural communities are usually busy medical practitioners who have been given an official title in order to conform with State laws or local ordinances. These men seldom have the time or special training to give leadership to a county-wide public health program.

Down in the Basement

Even in the counties where health departments are functioning, many rural people have never heard of them. They are housed so often in some dingy corner in the basement of the county courthouse that they can hardly be expected to provide the leadership necessary to guard the health of all people in the county. No wonder health departments are often looked upon as intended just for poor folks and not for the whole community.

Few Private Agencies

In most cities the health department is supplemented in its activities by the work of numerous voluntary agencies, such as the visiting nurses association, the tuberculosis association, the Red Cross, or other groups. But the large donations usually necessary to support such agencies are seldom forthcoming in rural communities. Although these agencies could supply nursing services in the absence of a health department, there are hundreds of rural counties that do not even have the benefit of a single public health nurse. Yet these nurses are the key figures in most programs to prevent disease.

Meager Welfare Services

For clients of welfare agencies—people who don't make even a bare living—some medical services are provided out of Government funds in most States. These services are generally very limited, however, both in volume and in quality. So many different agencies are generally involved that people don't know what to do for help when they need it. Too often the "county physician" who may be in charge of rendering services is a semi-retired practitioner. The public medical clinics which can be used by "welfare" patients or others in the cities are seldom found in the country.

FEWER HEALTH SERVICES RECEIVED

With this lean supply of professional people and facilities in the rural areas, it is obvious that farm people must receive far less than their due share of medical services.

Less Physicians' and Dentists' Care

It has been shown that for every 1,000 people in cities of 100,000 or over, 3,003 physicians' calls in the home or office are received per year; in communities of 5,000 to 100,000 population, 2,679 calls are received; but in towns under 5,000 and in the open country only 2,240 physicians' calls are received per year.

As for dental care, far less is received by rural than by city people and thousands of farmers have lost teeth that could have been saved by early care. Among thousands of farm people, dental care is practically unknown. It is not only their teeth that suffer but sometimes their entire system and, because of appearances, even their self-respect.

Less Hospitalization

Hospitalization, too, is far less in the rural areas. In cities of over 100,000 there have been 68 hospital cases per 1,000 population each year to every 42 cases in the rural areas. In the large cities, 858 days have been spent in the hospital by each 1,000 people per year in comparison with only 505 days in the rural areas. Only about half as many rural babies are fortunate enough to be born in hospitals as city babies. As we noted, it is not that country people *need* this much less hospitalization, but rather that they *get* this much less.

Fewer Surgical Operations

Rural people manage to obtain only slightly fewer emergency operations than city people. But for so-called elective conditions—that is, chronic disorders that need surgical attention but are not immediate matters of life and death—rural people get far less surgical care than city people.

Thus, rural people may not die from uncorrected hernias, infected tonsils, diseased gall-bladders, painful hemorrhoids, or what not, but they carry these troublesome handicaps and weakening conditions with them throughout their lives. Sometimes these chronic disabilities lead to acute emergencies.

Patent Medicines

About the only health items that farm people obtain relatively more of than city people are patent medicines—most of which are of very doubtful value. Great quantities of home remedies are also used, without the advice of a doctor. Of scientific drugs prescribed by a physician, the rural people receive less.

Whatever type of needed health service is considered, less of it is received in the country than in the cities. Even for people of the same income, those in the country appear to get fewer services than those in the city, simply because the doctors and the facilities are not at hand. More important, however, most people in the rural areas are of a far lower income level than city people. This we find is the main reason why rural health services are so poor.

WHY ARE RURAL HEALTH SERVICES SO POOR?

Careful study of all the facts seems to show that the main root of the problem of poor rural health services is economic. The situation is aggravated by the wide geographic spread of the rural population and all the social and civic difficulties that result from isolation. It is further complicated by certain psychological and educational barriers.

GEOGRAPHIC HANDICAPS

The thin scattering of rural people obviously makes it difficult to deliver to them technical services like medical care or, for that matter, electrification, or education.

Long Distances

Naturally, the construction of good roads and the increasing use of the automobile and telephone have served to overcome geographic handicaps to a large extent. Yet widespread rural areas are still without good roads or ample means of communication. The physician usually charges 50 cents or a dollar for every mile of travel out to

the farm house, so the fee mounts up. A long trip to the doctor's office, on the other hand, generally requires an effort the average farmer seldom wants to make, unless the ailment is pretty serious. The very distance of people from each other makes it difficult to organize any kind of community health program.

Isolation

Aside from these distance difficulties, the sanitation problems arising from rural geography create certain special hazards to health. Because of the prohibitively high cost of constructing a sewer system to serve isolated rural families, it is almost always necessary for human waste to be disposed of on an individual household basis. The same applies, of course, to the family water supply. The individual privy or the individual well can hardly be kept in as sanitary condition as a community-operated system.

Questionable Advantages

There are, of course, certain definite advantages to the rural environment. Sunlight and fresh air, freedom from the dust and fumes of industry, absence of the bustling crowds in which communicable diseases can be readily spread, and the generally slower pace of rural living are all real advantages, although they may be more than counteracted by serious economic problems. Even so, the benefits of the wide open spaces are easy to overemphasize and are in no sense a substitute for good health services. It should be remembered that many diseases, such as tuberculosis or venereal infection, require for their spread no greater contact with people than is found in the confines of a single house.

The warm climate, in fact, of our most heavily populated rural sections in the United States—in the Southeast—creates an environment favorable for the spreading of malaria. Likewise, the rural South abounds in just that type of sandy soil which is favorable for the transmission of hookworm disease.

PSYCHOLOGICAL DIFFICULTIES

Some of the deficiencies in rural medical care spring unfortunately from lack of education and understanding. Thousands of farm people have never had a chance to learn the elementary facts about keeping healthy. All the doctors and hospitals in the world could, after all, do very little good if people don't know or care about using them.

Attitudes About Medical Care

But it is easy to overemphasize this lack of education about health. Some people will contend that the low occupancy of rural hospitals or the insufficient use of physicians' or dentists' service is due mainly to certain typical psychological attitudes of farm people. They say that farm people—like quite a few city people—just don't like to go to hospitals or to doctors or dentists. They feel that the hospital is "a place to die in" and the doctor someone to avoid.

Experience is the Best Teacher

To some extent these attitudes are real and may come from a fatalistic philosophy, associated with a hard life close to the soil. They may be part of a rural culture pattern. If we think about it, though, we can see that these attitudes are assumed mainly as a "protection" or an adjustment of farm people to customary lacks. Basically, these feelings spring from lack of much actual experience with the remarkable benefits of modern medicine.

ECONOMIC PROBLEMS

The main reason for lack of experience with modern medical care, as we have said, is economic. Rural areas simply do not have the wealth and "purchasing power" of the cities. Even in 1943, with farm prosperity at its highest in years, income of persons on farms (from farming) was only 9 percent of national income, while farm families were 20.5 percent of the national population. The last Census of Agriculture showed that about two-thirds of our farm families had gross incomes under $1,000 a year and one-third had under $400 a year. The States with 70 percent or more urban population had incomes of about $800 per person in 1940, while States with 70 percent or more rural population had per capita incomes of only about $300.

"Wealth is Health"

The number of doctors in a community or the number of hospital beds or the number of services of any type received is nearly always dependent on the incomes of the people in that community. The less money, the fewer doctors.

The less money, the fewer hospital beds. The less money, the fewer services received. The less money, the weaker the public medical program. The less money, the fewer the voluntary agencies. The less money, the poorer the housing and sanitation.

Vicious Circle

This should not be a surprise. Doctors can hardly be blamed for wanting to settle in communities where they can find good facilities and make the best living. Hospitals can hardly be established where there aren't enough doctors to staff them or where people do not have the money to purchase hospital care and thereby maintain them financially. It's a vicious circle: without hospitals, fewer physicians; without physicians, fewer hospitals; without purchasing power, fewer of both. Something must be done to break the circle.

Great Need and Low Usage

As we've noted, we find the paradox of half-empty hospitals in the face of not nearly enough hospital beds to serve the true needs of farm people. It would obviously do very little good just to go on building fine new hospitals so long as so many rural people could not afford to use them. Certainly these new institutions are badly needed and must be built, but it would be foolish to do this unless at the same time ways are worked out to help rural people pay for the services.

Medical Expenses Are Unpredictable

There is a special point about the economic cost of sickness which should be kept in mind. Much is said about the high cost of medical care. Actually, it is only the relatively few people who have recently had big medical bills who spread the impression that medical costs are so high. In any year, there are a large number of people who have practically no medical expenses at all. At the same time, there are always a small number who have extremely high expenses. Figures show that in an average year some 68 percent of all rural families pay only 23 percent of the total medical charges for rural people, while an unfortunate 5 percent of the families pay 21 percent of all the charges. Just which group your family will fall in, you can't tell in advance.

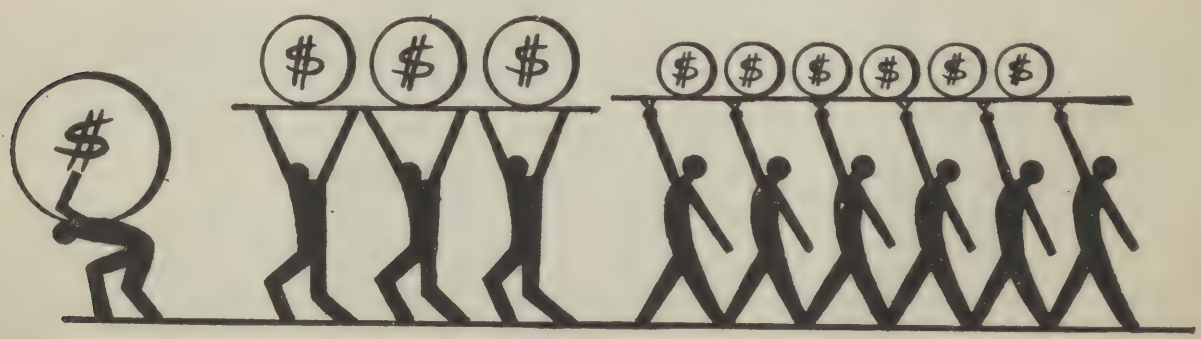
As a matter of fact, the rural families with the very lowest incomes tend to spend the highest percentage of their meager incomes to pay medical bills, even though they get less care. This is probably not only because their total incomes are so low but because they actually experience a greater amount of illness than people in the higher income groups.

Average Costs Are Not So High

Nevertheless, when we consider the *average* annual cost of medical care among, say, a thousand farm families, the amount is not so excessively high. Throughout the whole United States, taking into account all city and country families and the millionaires and needy alike, the average annual cost of all medical and related services for a family comes to about $90 or $100 a year. For a farm family the average expenditure is probably closer to $60 a year. It is true that modern medical science, with all its complicated diagnostic tests and treatment procedures, does cost more than the old-fashioned kind, but then what you're getting today is worth a lot more. Most important, if the cost is spread out over all the people in the community or the State or the Nation—in proportion to income—it doesn't come to a very high figure for any one family. When you figure it out, it is something like the menace of fires. They are pretty costly to the few unfortunate people whose property they strike, but averaged out over the whole community, through fire insurance, the expense is within the means of most farm families.

It's Not How Much Is Spent But How

Hundreds of millions of dollars are now being spent for medical care in the United States—but a lot of it is spent without much order or good judgment. If the total amount already being spent by the Nation as a whole were more reasonably planned—as we shall discuss later—good medical care could be available to every man, woman, and child. Many have come to realize that they cannot afford to be *without* good medical care.



WHAT HAS BEEN DONE ABOUT THESE RURAL HEALTH PROBLEMS?

Many rural people have been aware of these problems for years. Doctors, dentists, nurses, and druggists have worked heroically in rural communities to bring to farm people as much as they could of the benefits of medical science. They have worked as individuals—meeting emergencies as they arose.

PUBLIC HEALTH AND WELFARE SERVICES

The first big problem approached in a systematic, organized way was that of bringing better preventive services to farm people. About 35 years ago the first county health departments were organized in Jefferson County, Ky., and in Yakima County, Wash. After that, departments of public health were gradually organized in hundreds of rural counties around the country.

Local Health Departments

When the Social Security Act was passed in 1935, a great new expansion in health services was made possible. Under this act, millions of dollars of Federal funds have been granted to States and local communities, matched by contributions from them, to support the cost of an expanded, preventive health program. Health departments were organized in over half the Nation's rural counties. Through these funds also, hundreds of doctors and nurses and other personnel have been trained in the highly technical job of modern public health work.

Preventing Illness

Through public health agencies thousands of farm people have learned about the importance of proper sanitation, the proper care of infants and small children, immunizations, the importance of good food habits, methods of preventing the spread of communicable diseases. "Frontier nursing services," organized by voluntary groups, have brought health services to folks in the backwoods and up in the hills who otherwise might never have seen a doctor or a nurse. Medical examinations of children as well as instructions in good health practices have long been provided in some rural schools.

Public health measures especially beneficial to rural areas have resulted in the reduction in hookworm disease, pellagra, and malaria; the training of midwives; and the treatment of crippled children. The United States Public Health Service and the Children's Bureau of the Department of Labor have figured prominently in the leadership of this work. Of course, everyone realizes that much remains to be done if good public health services are to reach every county in the Nation.

Grants-in-Aid

The "grant-in-aid" mechanism which has been used to support most public health work is worth consideration. This policy had its start back in the 1860's when it was used to help set up the land-grant agricultural colleges. It represents a way of using the wealth of the whole Nation to help all of the States and to bring the general level of services in the less well-to-do areas up to the level of the average. The Federal Government acquires revenue from the people of the entire Nation, more or less in proportion to their earnings and spendings. Then it takes these funds and allots to each State an amount equivalent to what that State is willing to put up, itself, for the stated purpose. This represents the 50-50 method of allotting grant-in-aid funds.

Of course, the Federal Government doesn't have unlimited funds to match in this way, and so it determines the amount that should be allotted to a particular State for public health purposes by taking into consideration the population of that State, the extent of its health problems, its willingness to follow good public health policies, and other special factors. Recently, it has been considered more desirable for the Federal Government to allot money in proportion to the financial need of the State; that is, a poorer State might get 75 per cent of its public health budget provided by the Federal Government, while only 25 per cent might be provided to a more well-to-do State.

Welfare Medical Services

In addition to preventive services, health departments in some areas are handling medical care of needy persons. In most places, however, medical treatment for those unable to pay for it has been provided through welfare departments. In recent years, some public care has been pro-

vided for the medically indigent—that is, folks not on the relief rolls but still unable to afford a major medical bill—but this has seldom been done in rural sections. There are many different ways in which welfare agencies provide these medical services, and the cost may be borne entirely out of local or State funds, or with some Federal funds.

Since 1935 special Federal assistance has been given to certain particularly needy groups, chiefly the aged, the blind, and children who are without breadwinner parents to support them. Most of the funds spent for direct medical services to these persons, however, come from the State or local government. These deserving people need medical services as much as they need food or clothing or shelter.

To avoid "pauperizing" folks, all Federal public assistance funds must be given in the form of cash, so that the family can personally decide how it wants to spend the money. If medical services or drugs are called for, they may be given an extra allotment to cover the cost, but they are never forced in any way to spend this money on needed medical care. This has its good points, but the bad part of it is that in many States, particularly the rural States, there is barely enough money for food and shelter, let alone medical care. Twenty to thirty dollars a month, the usual amount for the aged, doesn't go very far. We can never be sure, therefore, that these people get the medical care they actually need.

The welfare medical services provided out of State or county funds, however, are usually paid directly to the doctor, the dentist, or the hospital. While this method is theoretically desirable, it has its bad points in practice, mainly because the funds at hand are usually far too scanty to cover the cost of all the medical care that is necessary. Moreover, there is a "means test," which subjects a person to an investigation to prove that he is poor. Various methods are used for actually paying the doctor—either by salary, by a fee for each service, by a fee for each person on his list, or combinations of these methods. Although greater financial support is badly needed, welfare agencies have shown how medical services can be provided to the "relief" section of the population, with the cost being borne out of government funds.

THE DEPARTMENT OF AGRICULTURE'S HEALTH PROGRAMS

For many years the Department of Agriculture has taken steps to help farm people improve their health.

Nutrition and Hygiene

Important work has been carried out by the Bureau of Human Nutrition and Home Economics on the essentials of a balanced diet. Many diseases of animals, which also affect man, have been controlled through the aid of the Bureau of Animal Industry. In the field of health education, the Federal and State Extension Services have done notable work in many sections. Through Home Demonstration and 4-H Clubs, the fundamentals of sound health and hygiene, especially nutrition, have been brought home to thousands of farm people. Other Bureaus of the Department have also promoted rural health.

Environmental Sanitation

In order to strike at the cause of filth-borne disease, the Farm Security Administration has made loans and grants to individual farmers to enable them to adopt sanitary measures. Tens of thousands of farm families have been provided with sanitary privies, or better-constructed wells, or have had their houses screened through this program. The Soil Conservation Service has helped to bring good water supplies to thousands of farms. The Rural Electrification Administration has brought refrigeration to many farm homes probably saving the lives of many babies by preventing spoilage of milk and other food.

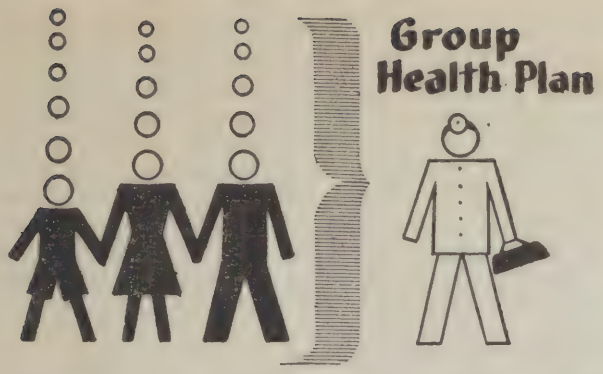
Health and Successful Farming

Perhaps the most important step taken to meet the need for medical and dental services among farm people in an organized way has been the health program of the Farm Security Administration. This program was organized with the assistance of the United States Public Health Service and the cooperation of professional societies all over the Nation. Starting slowly in 1936, it grew out of a recognition of the fact that health often contributes to success or failure in operating a farm. On the one hand, sickness might incapacitate a man so that he could not do a good day's work. On the other hand, bills incurred because of serious sickness often meant that a man could not afford to buy fertilizer, seed, or the equipment needed to run his farm, or even to pay back a loan that might be made to him.

To help solve the problem, attention was given to the uneven way in which sickness strikes and the heavy weight with which it falls on only a few families each year. The time-honored principle of the farmer's cooperative was brought in. If farmers could pool their funds to arrange for marketing their crops or to buy farm supplies, why not pool them to buy medical services?

FSA Group Health Plans

The plan of operation is rather simple. All the FSA borrowers in a county are asked to join a "group health plan" by voluntarily setting aside a certain sum of money each year to go into a pooled fund. This amount, the membership fee,



is geared to the ability-to-pay of the farm families involved. The amount varies, of course, in different parts of the country, but is the same for all the members in any one plan. If a farm family is able to pay this amount out of its own resources, it does so; otherwise a loan is made to cover the membership fee. These loans, as a rule, are simply part of the loans made for other items of good farm management, such as for purchasing seed or fertilizer.

In most of these plans the families receive the services of their family physicians—usually general practitioners—in the office or at the home, and use the drugs dispensed by them. For these services the average family membership fee is about $18 or $20 per year. If additional services are provided, such as surgical operations, hospitalization, dental services, or specially prescribed drugs, additional amounts have to be paid into the fund. To give an idea of how this has worked out, we find that at the beginning of 1944, 87 per cent of the members in these group health plans throughout the country were entitled to physicians' services, 64 per cent were entitled to additional surgical services, 67 per cent hospital care, 42 per cent dental services, and 30 per cent were entitled to specially prescribed drugs. Since membership fees in these plans are set rather low, being related to the general level of incomes of the membership, it is usually necessary to restrict services to some extent. Otherwise, the fund would give out and the plan would fail. To avoid this, care is often limited to emergency cases, though sometimes the idea of "emergency" is quite broadly interpreted.

Free Choice of Doctor

Before a plan is set up in a county, the full approval of the county medical or dental society is obtained, and the doctors wishing to participate sign an agreement. All professional matters, such as fee schedules or relations among the physicians or dentists, are left to the professional societies. The funds collected from the member families are deposited in a special account and held by a trustee, or by the treasurer of a board of directors chosen by the members, for use throughout the year. The doctors or dentists or hospitals or druggists in the usual plan then submit their bills to the trustee or the treasurer for payment. The families have complete free choice of the practitioners in the plan and they can feel assured that any time during the year that sickness strikes they can go to the doctor without fear of having to lay out money at the time.

Prepayment and Proration

We might ask how one can be sure that the funds set aside at the beginning of the year will pay for all the medical costs that may be incurred. For a large group of people, we can tell fairly accurately what the average cost will be, even though we cannot predict the actual expenses of any one family. It is not necessary, furthermore, to be absolutely accurate about predicting these over-all costs.

Here is what is done: The total funds for the year are divided into 12 monthly parts and bills are paid each month on the basis of the funds available for that month. Thus, if the total yearly funds amount to $12,000, $1,000 becomes available each month. If, in one month, bills totaling $900 are presented for payment, they can naturally be paid in full, with $100 then being carried over to the end of the year. If in another month, however, bills amounting to $2,000 are presented for payment, each bill is paid only at 50 per cent of its value. At the end of the year, any surplus funds carried over are used to pay on a "pro rata" basis any bills not paid in full during the previous months. If, after this is done, all bills are still not paid 100 per cent, the account is simply written off. Sometimes all bills are paid in full and money may even be carried over to the next year. On the average, it is found that about 75 per cent or more of the physicians' charges submitted are actually paid.

Doctors Are Satisfied

While this might not sound so good from a business point of view, it represents actually far better payment than many of these professional people formerly received from these lower-income farmers. In very few instances have the professional people been dissatisfied with the percentage of payment of their bills to the point of wishing to discontinue the plan. It should be kept in mind that under this plan physicians are not on a government salary, nor are patients forced to see doctors that they do not like. Patients see doctors of their own choice in their private offices just as they did before, and the only thing lost is the worry of getting the bill paid.

Over 1,000 Counties

Farm people like the idea because, with payment of the bill eased, they get more service. The doctors like it because they get better and more prompt payment for their work. The good common sense of these plans is demonstrated by the fact that they grew from plans involving eight counties in three States in 1936 to plans covering

over 1,000 counties in 41 States and Puerto Rico in 1943. In the very poorest States, where medical needs were greatest, the plans grew most rapidly.

Experimental Health Programs

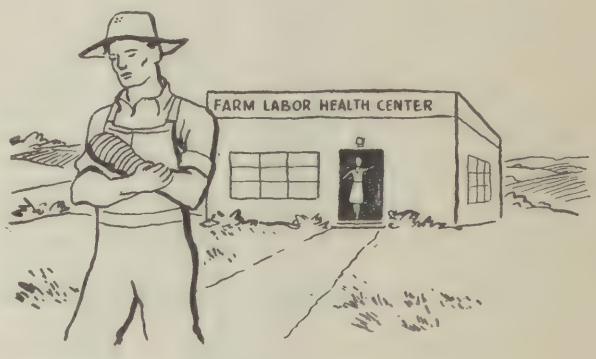
In several counties around the country the same general pattern of health insurance has been applied by the Department of Agriculture in experimental plans open to all farm families (not just FSA borrowers). The idea of voluntary group prepayment for medical services has proved so successful that the Department was interested in getting some insight into how this principle might work for the whole rural population in the postwar period. Furthermore, an effort was made to provide for reasonably complete services without the restrictions necessary where services had to be geared to the "purchasing power" of farm families. In order to assure such relatively complete services, it was necessary for the Federal Government to make outright grants of funds to the health associations in these counties to supplement the payments made by participating farm families.

Membership fees in these special plans vary with an individual family's ability to pay, rather than being a flat rate, as in the standard FSA plans. Each family pays 6 per cent of its net cash income, with a certain minimum being set at about $12 or $15 a year and a maximum usually set at the full annual cost of the services per family. This particular percentage was chosen because it represents a rough average of what farm families have been paying annually for medical care throughout the United States. The Government funds are then used to make up the difference between what the family contributes on this basis and the actual average annual cost. The average cost per family for the reasonably complete medical services provided generally comes to about $50 a year.

Migratory-Labor Health Services

For one of the lowest income groups in the farm population—the migratory farm workers—a special and different pattern of organizing and financing medical service was necessary. This constantly shifting group could not be expected to make even a small contribution toward the payment for needed medical services, either on a group prepayment or on an individual basis. They are somewhat like those on public-assistance rolls in that they can be assured of health services only when the cost is borne entirely by the Government.

To provide migratory farm workers and their families with decent housing and sanitation, the Federal Government has set up camps throughout the country at points of seasonal labor concentration. In each camp is a clinic or health center, attended by a registered nurse. Local physicians or dentists are engaged to hold regular clinics for the workers and are paid usually on a per hour basis, which is like a part-time salary. If a farm worker gets sick and needs immediate attention when a clinic is not being held, the nurse sends him to the office of a private physician and the physician is paid on the basis of a fee schedule. Payment is also made for any surgical or hospital care needed. These payments are not actually made by the Government directly, but by nonprofit, incorporated agricultural-workers' health associations which are financed by the Government.



Office of Labor

This program for seasonal farm workers was started by the Farm Security Administration and taken over in 1943 by the Office of Labor of the War Food Administration. It has proved flexible enough to furnish health services of all kinds to people continually on the move and especially to about 100,000 foreign workers brought into the United States from Mexico and the West Indies to meet wartime farm-labor shortages. Because of these precautions, the spread of disease across State or national boundaries has been largely prevented.

Prevention and Treatment Both

The farm-labor health program has taught valuable lessons about bringing health care to isolated communities. Clinics have been set up in such localities as centers of health service for workers throughout the area. The nurse in charge of the clinic does a big job in promoting preventive measures of all kinds, handling first aid and minor complaints, visiting sick workers in their quarters, and seeing that medical or dental attention is given to those who need it. A doctor who may have to come from quite a distance holds a regular clinic three or four times a week and is on call for emergencies reported by the nurse. In some areas a fully equipped dental trailer, with a full-time dentist in charge, visits each camp or clinic at regular intervals. Occasionally a doctor has been engaged on a salary to handle the medical work in several camps, when no local doctors were available to do the job.

Rural Health Centers

Outside of the farm-labor program, rural health centers have been set up in connection with resettlement projects for low-income farmers in many parts of the country. At least 30 such health centers, each with a full-time public health nurse, offered a place where both preventive and therapeutic health services were rendered. In several of these centers, such as at Tygart Valley Homesteads, W. Va., or Dyess Farms, Ark., full-time physicians were engaged on salaries, paid by a local health association from a prepayment fund. Auxiliary hospital or infirmary beds for emergencies or maternity cases were provided in certain of the centers. A similar program, utilizing 3 health centers and a well-rounded staff of salaried physicians, nurses, clinic aides, and a dentist, has been serving several thousand Spanish-American farm people in Taos County, N. Mex., since 1942.

LESSONS OF THE USDA EXPERIENCE

From the broad background of experience in the Department of Agriculture's health programs, many lessons can be drawn which should be of value in planning post-war health services for the whole rural population.

The Strong Side

On the good side, the organization of FSA group prepayment health plans has certainly helped farm people get a great deal of medical service that they would otherwise have done without. Farm families have been given a sense of security which is, in itself, of great value. Further proof has been gathered that the insurance principle works as applied to health, and that under it doctors, dentists, and hospitals can be paid for the services at rates satisfactory to them. The great majority of members like the plans and, until certain difficulties caused by the war were encountered, the total membership increased year after year.

The professional groups also like the plans and, though there was often some hesitation at first, in most places the medical societies are now strong supporters of the idea. Rural medical practice and rural hospitals have been financially strengthened by the program and, therefore, the supply of personnel and facilities has to some extent been kept up in rural communities. Farm manpower has been preserved during the critical war period, with a probable reduction in time lost by farmers due to sickness. Finally, a great many farm people have been educated by this experience about the importance of positive action to better their health services.

While the percentage of the whole farm population covered by all FSA plans has been small, it has been widely distributed, so that some experience in health insurance has been provided in practically every State and in over one-third of the counties in the country. A great deal has been learned about the costs and the organization of health services for farm people.

The Weak Side

On the unfavorable side, however, there are many other lessons to be learned from this experience before we set out to plan for the future.

On a voluntary basis, it has been found that too small a percentage of farm families that could join plans actually do so. In counties with plans in operation, less than 50 percent of the FSA borrowers join them. Naturally, these tend to be the families who are, from the insurance point of view, the poorest risks—that is, they are the people most frequently afflicted with sickness or physical defects needing medical service. This means that costs for everyone have to be relatively higher. Since the amount of money available from the families, however, is limited, it means that in order to get paid enough for each service, the doctors and others tend to some extent to limit the number of services rendered.

The very confinement of FSA plans to lower-income farm families means necessarily that each family can contribute relatively little, and there are no contributions from higher-income families to bring up the average. This often means, as we have noted, that services are restricted to emergency cases and other limitations have had to be imposed. The organization of these plans, typically along county lines, in conformity with the general structure of the Farm Security Administration as well as the medical societies, has in itself limited the number of families that could join a particular plan.

On this single-county basis, the provision of really complete medical services requires, as shown in the experimental health programs, a great deal of outside subsidy. If more people of all income groups were members of these experimental plans, these plans might be more nearly self-supporting, without requiring so many thousands of dollars of Federal funds.

Little Improvement in Quality

Being part of a general rural rehabilitation program, under the direction of a county supervisor with many other worries, the plans have often been allowed to just drift along with very little guidance. The member families themselves have seldom taken an active part in the management of the plans, because no one has found time to explain to them just how the plan works, or what part they could play in it. Because of this lack of direction from enough specialists skilled in the technical field of rural health administra-

tion, very little has been done to raise the actual quality of rural medical care. Modern preventive services or the skills of specialists have been offered only sparingly. The actual provision of services has been left in the hands of the country doctors on the spot, without any attempt to aid them in getting up to date on the latest developments in medical science. Except for some of the services in the farm labor program and in a few FSA plans, the pattern of paying doctors has been kept crystallized in the traditional fee-for-service way.

Paying the Doctor

This question of *how* the doctor is paid for his services is very important. It is important because, depending on how he is paid, the services may be more or less expensive to the persons footing the bill. The commonest method of payment is that found in the usual FSA group health plan, in which the doctor is paid a separate fee for each service—the "fee-for-service" method. In some FSA plans, however, he is paid on the so-called capitation basis, whereby he gets a fixed sum of money per month for each family on his list, no matter how little or how much service is rendered to a particular family. The method used quite extensively in the farm labor program—the per hour or part-time salary method—pays the practitioner for his time, without regard to the amount and precise kind of services rendered in that time.

Although most doctors thinking along traditional lines seem to prefer the fee-for-service method, experience has shown that it has its defects. A great deal of red tape is required in record-keeping and supervision. Abuses tend to creep in when every item of service is related to dollars and cents, and a high-quality program emphasizing preventive services is hard to build when this method is used. The capitation plan, on the other hand, is a useful and simple method for everyday family-doctor care. This plan, however, requires some attention to be sure that patients are receiving all the medical service they need.

The experience in our finest medical centers, like the great medical schools, shows that paying physicians on the basis of *time* is probably most economical and yet it actually provides the basis for the highest quality service. A very skillful doctor or a well-trained specialist, of course, should get higher "time-fees" than a less experienced or less competent physician. This whole question has to be carefully considered in any postwar plan for health services.

Wartime Stresses

In a sense, the greatest virtue of the agricultural health program has been also its greatest weakness. It has concentrated attention on the question of payment for medical services because this question is most fundamental of all. In so doing, however, other important aspects of medical care have been somewhat overlooked.

During the war, the FSA health plans have been subject to many stresses which tend to expose their weaknesses. Civilian doctors became fewer and, with higher farm income, the demand for their services on a private basis increased. Physicians began to lose interest in the plans and people began to feel they no longer needed the economic protection they offered. Memberships began to fall off soon after the war began and many of the weaker plans collapsed. Basically, the failures were due to the handicaps which are associated with the restriction of plans to lower-income people, in single counties, on a voluntary basis.

Corrective Measures

In order to overcome these difficulties, attempts have been made to broaden the membership of the plans. One way has been to develop plans on a wider-area basis, including several counties or even whole States. This could be done most readily for hospitalization and surgical services, since it is easier to systematize the payment for services rendered in a few institutions than for services rendered by scores of different rural physicians. Another way of broadening membership has been to include in the plans farm families who were not FSA borrowers. Ordinarily, doctors tend to object to including nonborrowers in plans since they want to charge higher private fees for these higher-income families. But in a few places they have recognized that such a policy is necessary if plans are to be kept on a good paying basis. Closer cooperation has been sought with State and local departments of health, so that the preventive program of the health department could be integrated with the medical-care services of the prepayment plan. Efforts have been made to increase the participation of farm families in the management and improvement of their own plans.

These corrective measures give some hints as to what is needed to develop a successful health program for the whole rural population.

OTHER EFFORTS TO IMPROVE RURAL HEALTH SERVICES

All this discussion of the health program of the Department of Agriculture is not meant to imply that other groups have done nothing about rural health. Several other programs, specifically devoted to the welfare of the farmer, have done valuable pioneering.

A Cooperative Hospital

Perhaps the best known of these other programs is that of the cooperative hospital owned and operated by the Farmers' Union Hospital Association at Elk City, Okla. The physicians here are on salary and practice as a group. A family of four pays a membership fee of $25 a year, with $6 extra for each additional family member. Certain extra charges are made for home calls, surgery, maternity service, and so on, and the purchase of a $50 share in the co-op is required of all members. With the high initial cost of constructing hospitals, it is no surprise that this particular pattern has not spread more widely. After all, it seems unfair for the cost of constructing a hospital to fall just on the shoulders of those group-minded people who make up a co-op's membership. The cost of building a community institution should ordinarily be borne by the entire community, preferably out of public funds.

Local Prepayment Plans

In the Sandhills section of Nebraska a rural health association has started a prepayment plan for health services and brought a physician on salary into a sparsely settled area where there were no physicians at all. A small clinic was established and a public health nurse was brought in with the help of the State health department. The Farm Foundation has promoted this type of action and farm leaders in many states would like to see this Nebraska experience copied. Somewhat similar plans have been started in certain sections of Utah. In connection with cotton mills or lumber mills or mining centers in rural areas, a number of prepayment plans have been sponsored—sometimes by the employers, sometimes by the employees, sometimes by both. These plans help a good deal, but they are usually meagerly financed and give rather incomplete services.

Blue Cross Plans

The Blue Cross program of hospitalization insurance has been almost entirely a city development, but in a few areas efforts have been made to cover farm people. The chief problem in providing this or any other type of insurance to farm people is the development of a simple system for periodic collection of premiums. To solve this, the farm bureaus in some States have agreed to collect hospitalization fees from their members and consider the hospitalization insurance as a benefit of membership in the farm bureau. Of course, hospitalization costs tend to be high when they occur, but on the average they amount to only about 15 percent of total medical expenditures throughout the Nation.

Commercial Sickness Indemnity

In some other States, the farm bureaus have enrolled their members in group insurance plans, carried usually by commercial insurance companies, providing a cash allowance in case of sickness. While such plans are of some value as insurance against medical costs, and against a loss of earning power during illness (less applicable to farmers, of course, than to industrial workers), they fail to really guarantee the provision of needed medical services in time of sickness. Some of these "sickness indemnity" plans are limited to coverage of accidents, and most of them do not pay benefits except for illnesses that last longer than 7 days.

Demonstrations in Modern Services

Certain philanthropic foundations have sponsored projects in medical services for rural people on a demonstration basis. Chief among these are the Commonwealth Fund with its activities in the field of hospital construction and public health services in a number of States; the Kellogg Foundation which has helped to organize health departments and hospitals in several counties in Michigan; the Rosenwald Fund, which has done much for Negro health; and the Bingham Associates Fund, which has developed plans for coordinating rural medical practice in Maine with the specialized services available in some of the larger cities in the State and in Boston. The main value of these projects has been to show that, if money and leadership are available, some of the serious difficulties of rural medical care and the handicaps of rural medical practice can be overcome and good services can be provided. Rural demonstrations in preventive or public health services have been carried on by the Rockefeller Foundation, the Rosenwald Fund, and several others.

Private Agencies

Of course, the activities of numerous private health and welfare agencies have had their effects in rural areas. Chief among these have been the programs of Visiting Nurses Associations, the National Tuberculosis Association, the American Social Hygiene Association and the American Red Cross. As we have seen, though, the sparsity of rich donors in most rural areas has meant that these voluntary programs have done much less in the country than in the cities.

Medical Society Plans

Many medical societies, watching the trend of the times, have set out to see what they could do about the problem of medical care themselves. About a dozen of the State medical associations have set up some kind of prepayment plan, usually one that covers little more than surgical and possibly maternity care. These plans are confined almost entirely to city people. Actually, the chief attention which the medical societies have given to rural needs in an organized way has been through the Farm Security Administration health program.

Public Works

As an outgrowth of the depression a great many hospitals were constructed with the aid of Federal funds, though most of these were in the cities. Over 3,000,000 sanitary outdoor toilets were constructed by the WPA in all parts of the country.

War Emergency Programs

With the war, certain emergency Government programs were started which helped rural areas a little. The Community Facilities Act, for example, provided for the Federal construction of hospitals, health centers and sanitation projects in areas seriously congested because of war production or military mobilization. Most of this construction was done in cities, but in a few places, where small urban communities act as trade centers for rural areas, farm people benefited. Into many of these "congested war areas" the U. S. Public Health Service sent public health physicians, nurses, and engineers, providing sometimes the first taste of a public health program these areas ever had.

Another step was the establishment in the War Manpower Commission of the National Procurement and Assignment Service for Physicians, Dentists, Nurses, and Veterinarians, which, in addition to recruiting professional personnel for the armed services, had the job of relocating physicians and dentists from areas where there were plenty of them to areas where they were badly needed. This has been done on a voluntary basis and has not been as effective as many would like to have seen, but the idea of an over-all agency doing something to redistribute the available supply of professional people has been established.

The program of Emergency Maternity and Infant Care, for the wives and infants of servicemen in the four lowest pay grades, is helping to bring into the world under good conditions thousands of GI babies in rural and urban areas alike. The Federal Government is paying for this through the Children's Bureau, and health departments throughout the country are administering the program in cooperation with the local doctors and hospitals providing the service.

This about completes the story of what has been done in an organized way to improve rural health services.

WHAT HAS TO BE DONE NOW?

Careful consideration of the problems presented, and their underlying causes, points up the main objectives to be reached if American farmers are to achieve a parity of health services with the rest of the Nation.

Improvement of farm income and rural living conditions and rural education would, of course, go a long way toward solving the problems. But beyond these are certain immediate objectives toward which farmers can aim right away.

Five Objectives — One Goal

Here are the objectives—the things we must do to satisfy the needs of rural people:

1. We must do something to ease the payment of the medical bill.
2. Facilities, like hospitals and health centers, have to be constructed and sanitation must be improved.
3. More doctors and dentists and nurses must be brought to the rural sections.
4. Good preventive public health services must be organized and people must be better educated about health and disease.
5. The scientific quality of rural medicine and related services must be elevated.

Not all rural people see things this clearly and part of the job is to bring these goals within the vision of all of them.

Some of the geographic difficulties standing in the way of reaching these objectives are largely beyond our control, but there are several things we can do about the economic and psychological problems. There is no difficulty that good, active community organization cannot help to conquer.

All five objectives are part of the same goal of better rural health. They are really inseparable. Hospitals are of no use without doctors, and doctors can hardly do a proper job without hospitals.

Prevention and treatment have no real line between them. The cure of a disease may prevent it from spreading to another and the early treatment of all illnesses tends to prevent serious complications. It's only for practical convenience that we speak of five separate objectives. To reach the one goal of better rural health, we must try to achieve all five at the same time.

Many Minds at Work

Fortunately we have the benefit of the thoughts of many people who have considered these problems. Postwar planning committees in nearly all the States, sponsored usually by the land-grant agricultural colleges, and cooperating with professional groups and governmental agencies, have deliberated on the problems of rural health and have come forth with many practical suggestions. The best of these, combined with a careful consideration of the lessons of past experience, provide us with valuable information on the *methods* by which we can gain the desired objectives. Above all, what we need is organization and group action. Let's consider each of these five objectives in turn.

EASING THE PAYMENT OF THE MEDICAL BILL

We have seen that the most basic problem of all in improving rural health services is getting the medical bill paid. Without this we cannot expect doctors to settle in rural areas, hospitals to be constructed and properly maintained, or services of a high quality to be rendered. We have noticed how the insurance mechanism of the prepayment plan levels the unpredictable costs of medical care when funds are pooled from a large group of families. The question is what to do about it.

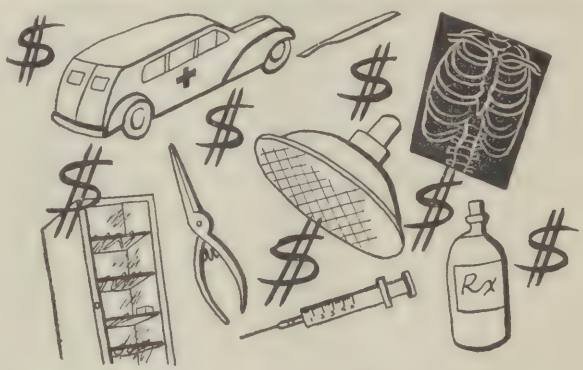
Form a Community Health Committee

The simplest answer would seem to be to set out and organize a prepayment health plan right in your county. Get together the farm leaders and as many people in the area as possible and talk it over. Call in the heads of all the local farm and social organizations, educational groups, and local church leaders. Seek technical advice from the local doctors and the health department staff. Form a county or community health committee to study the problem and to organize a health association to carry out the program.

A Local Prepayment Plan

Keeping in mind that the average American family has recently been spending about $90 or $100 per family each year for medical services, the committee can decide how much the local people could afford to pay on the average into a prepayment plan. The simplest way would be to charge everybody a flat rate, set at about the average ability to pay in the area. The objection to this method is that many families with low incomes might be unable to join the plan or could do so only at the sacrifice of essentials like food or clothing.

Charging in proportion to income would be a lot more fair, even though it would require filling out income statements of some kind. Thus, if membership fees were based on 5 percent of net income, for example, the family making $1,000 a year would pay $50, while the family making $500 a year would pay $25. Of course there ought to be a minimum fee of, say, $10 or $15 a year and a maximum of $100 or so. It's not so good to vary fees with the size of the family, because this makes it harder on the larger families, though single persons and couples without any children might pay less. This whole method would be like the time-honored "sliding scale of fees" that doctors follow.



The Costs of Medical Care

Then you have to figure out what services can be obtained for the money. The costs naturally depend, as we have seen, on the way services are charged for and the predominant method in the United States is fee-for-service, which is more or less expensive. The fees for professional services, moreover, vary in different parts of the country, but here are some rough figures to go by—figures drawn up bearing in mind the lower average incomes of rural people.

For the services of the general practitioner—office and home calls and maternity care—a family might pay between $15 and $20 a year. For the services of the surgeon in the hospital and of other specialists they might pay between $7 and $10 a year. For limited hospitalization, they might pay between $8 and $12 a year. For basic dental care, they might pay between $6 and $12 a year, depending upon the completeness of services allowed. (Naturally, if bridgework, for example, is to be allowed, it would cost a lot more than the figures given which are based on services like extractions, cleanings, treatments, and fillings.) The provision of prescribed drugs should

probably cost a family no more than $5 to $7 a year. Special nursing services might be covered by $1 or $2 a year. Administrative costs would come to about $3 or $4 a year (or more accurately 5 to 10 percent of the total cost of services). A contingency fund for emergency conditions or for certain special services, like orthopedic appliances or eyeglasses, might come to between $3 and $5 a year.

The plan for all these services, therefore, would cost a family on the average between $48 and $72 per year, or $4 to $6 per month, depending on the section of the country. Certainly every effort should be made to have a plan with this reasonably complete set of services. If the local farm families cannot afford this, however, you may have to be satisfied for a while with partial services. For such partial services like general practitioner care alone, or just hospitalization and surgery, or dental care alone, or any combination of services, the cost would, of course, be proportionately less.

Arranging Professional Agreements

The next step is for the health association to go to the providers of services—the doctors, dentists, hospitals, druggists—and work out agreements with them (through their professional societies) under which they will render the needed services and be paid out of the pooled fund. Professional groups are beginning to recognize that this method of prepayment simply provides a convenient way for families to budget their health expenses in advance so that actually the payment of the professional bill is more firmly guaranteed. In almost every community you will find doctors who have thought about the matter and can help out a great deal.

Enrolling Members

The health association's program should be started only when a large enough membership has been built up. Experience shows clearly that the broadest possible membership is essential to success. One good way is to enroll members through existing farm and social organizations. It is a good idea also to require that any organization or group joining the plan should come in with 50 percent of its membership or better. In this way, some assurance can be obtained that there is a good selection of risks and that the plan is not attracting only the least healthy people or those who will demand the most service. In general, it's pretty shaky business to start a plan with fewer than about 300 member families. And 600 families would make it more than twice as stable. The more the better.

Technical Assistance

Some technical assistance for this whole job might be obtained from the county extension agents or the county supervisor of the Farm Security Administration. Possibly the local health officer could offer some help. The county welfare director and the local superintendent of schools might also be helpful. If there is no one locally who can help on this kind of organizational job, assistance might be obtained through the State health department or the State extension service, as well as through the Surgeon General of the Public Health Service or the Secretary of Agriculture in Washington. Regarding maternal- and child-health services in particular, the Children's Bureau in Washington can be of assistance.

To assure the success of the local plan, it is highly advisable for the health association to choose some one person to work more or less full time on the job. If about 1,000 families or more are enrolled in a prospective plan, there may be enough money available to pay the salary of a full-time manager for the health association. It's a good idea also for the administration of the plan to be tied in as closely as possible with the local health department.

Paying the Bills

As to the details of financing services, probably the simplest method is to use the proration system, with definite allotments of funds per month, which has been described above. By using this system, there is a sort of safety valve which, in effect, prevents the collapse of a plan in case the charges for service exceed the amount of money on hand. Whether a plan is for partial or complete services, it's wise to keep the funds for each type of service in a separate account. This forestalls the financing of one service at the expense of another.

As for the method of paying the professional people, they themselves will nearly always prefer the fee-for-service system, and it is probably wise to leave that decision in their hands. After a while it might become clear to everybody that there are some serious flaws in this system, as we have noted, and everyone may agree to change to some other method. The economies of payment to a group-practice clinic, which will be discussed below, might come to be appreciated.

All Income Groups

When the prepayment plan is proposed to the local professional groups, you may find that they would prefer to confine it to low- or moderate-income rural people. It is argued that the more well-to-do people can come and get service on a private fee basis. Nevertheless, experience proves that the most stable plan—the plan that will "pay off" best—is the one with the broadest possible range of income groups in it.

As a matter of fact, people in the very lowest income groups can seldom afford to purchase membership in such a voluntary plan. This would apply, for example, to families receiving

public assistance. For these people, it might be possible to work out some system with the local welfare authorities, whereby their membership fees would be paid for them by the public agency or they would be given some special allotment in order to pay for membership in the plan themselves.

Use Other Community Health Services

A final point to keep in mind in organizing a local prepayment plan is to avoid duplicating services which other agencies are already prepared to give. For example, if immunizations are already being provided by the health department, they need not be covered in the plan. The hospitalization of cases of tuberculosis or mental disorder is conventionally provided by some State or county agency, so these services need not be included. Certain laboratory tests for venereal diseases as well as the treatment of these diseases, usually furnished by the health department, may be excluded from coverage in the plan. The same might apply to the services of visiting nurses, which may be provided by a local voluntary agency, or to health services available to children through the schools.

In other words, the plan should provide services that are not otherwise available—but you should be sure that if services are excluded they are definitely obtainable in some other way. In fact, a county health association is in a position to promote the expansion of public health and public medical services in the community by the official agencies.

If such a local plan is organized, many people will learn how the insurance principle can be applied effectively to health services. Valuable experience in the administration and financing of prepayment care will be gained.

Still, we know that this will be solving only a small part of the payment problem. We have seen how membership on a voluntary basis and within the confines of a single rural county can encompass only a small percentage of the people and, because of the necessarily unfavorable selection of risks, the cost per person must be relatively high and the services must be relatively restricted. If family costs are to be reduced and if benefits are to be expanded (such as including the services of specialists), it is necessary to go beyond the limits of county lines.

A Multicounty Plan

Organizing a prepayment plan over several counties is a harder job but it can be done. It is fairly easy for a hospitalization plan, as we noted above, where only one or two institutions may be providing service to the people in several counties. For medical services where several dozen doctors may be involved, it is certainly more difficult, but it can be done. If representatives of the different county professional societies can be brought together to sit down with a committee representing the families, a plan may be worked out which will be agreeable to all.

State-wide prepayment

To do an even better job for everybody concerned, a health insurance plan could be developed to cover the entire State. Such a plan, of course, would require a good deal of organizational work, with probably several full-time employees. It can only be done if many people from different sections of the State get together and work it out very carefully. They can form a State health committee to develop a State-wide medical care plan. Of course the broader the membership in such a plan, the stronger and more effective it can be. Participation by people from all walks of life and from all income groups—rural and urban alike—can mean the highest possible average of family contributions and maximum benefits for all who take part.

Broad Representation

There has been some tendency in State health committees, already set up, to have the dominant representation from professional groups and other experts, simply because they know most about the technical details of medical care. Of course, technical advice is essential and it should be sought from agencies like the State department of health, the welfare department, and the State medical, dental, and hospital associations. It is still very important, however, for farm people, as well as other sections of the public, such as labor organizations, religious groups, educational and nutrition committees, women's clubs, and so forth to be fully represented on such State health committees. It's essential to give a strong voice to the consumer who pays the bill for medical services. This is not only democratic, but it's good common sense to have the benefit of the experience and judgment of these groups.

Recently, legislation has been proposed in some States which would include almost all wage-earners in State-wide health insurance plans. Such plans would of course benefit most rural people only if farm operators and farm workers are covered.

Social Security With Health Insurance

Even with a number of State plans organized—whether voluntary or "compulsory"—there would still be lots of people in urgent need of care who would not be included. We would still face the fact that certain States—most often the rural States—are poorer than others, with much lower family incomes on the average. Many doctors and others who have studied this problem for years have suggested a way through which rural people and people living in the rural States could get the benefits of medical science that are much more available now to residents of the wealthier

industrialized States. They point out that the contributions of people in all the States, depending on the size of their incomes, could be pooled in one large health insurance fund. Then the payment for medical services out of this fund could be made to communities in proportion to their needs.

A proposal along these lines is now receiving serious consideration. It calls for extending the Social Security program to farm families and for adding health insurance to the old age insurance and other benefits now enjoyed by most city people. There has been a trend, of course, all over the world as well as in the United States, toward adopting measures which give people some security against the hazards of unemployment, old age, disability, and illness. Through "social insurance" people earn the right to benefits based on their own contributions. By applying this idea to payment for medical care, people would contribute directly into a national health insurance fund for the services they would receive—rather than having their care paid for from tax funds. Of course many other health measures such as public health work and related services would still be financed through taxation.

It would not be very difficult to include farm people in Social Security even though their contributions could seldom be handled through any kind of automatic deduction from wages or income. It has been suggested that instead of making regular periodic payments, the farmer might pay his social insurance contribution once a year, along with his income tax or by some similar method. Farm workers could be covered by a "stamp plan," with contributions paid at the Post Office and with receipts in the form of stamps kept in a small book.

No Need for Bogeymen

If such an extended national Social Security program, covering farm people and including medical care, should develop in this post-war era, our medical care would not be "handed out" by some agency in Washington. Certainly a plan would still have to be organized for local provision of services, just as in the case of the county plan we discussed first. People would still be served by their regular family doctor or whomever they chose. In fact, money would probably be available to pay this doctor for more services than the individual rural family could afford before. The only difference would be that the financing would come from all over the Nation instead of from the individual pocketbooks of the people who happen to get sick.

It might be a good idea to discuss all these things with other rural people and to find out as much as possible about Social Security and related matters. With national health insurance legislation being considered, it is important that the rural population be intelligently informed.

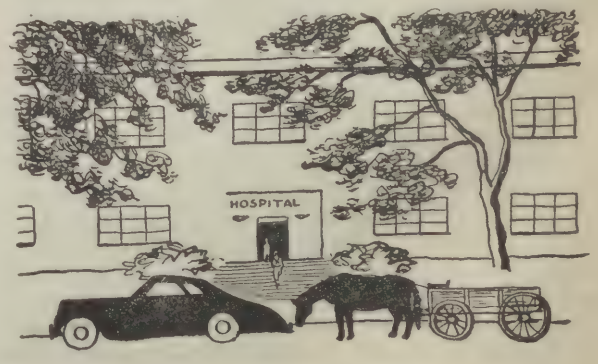
Meanwhile Strengthen What We Have

Of course, until a Nation-wide health program can be developed, the present Federal health program for migratory farm workers should be continued and strengthened. In fact, there may always be need for special facilities for this group in our rural population, for when thousands of seasonal workers pour into some areas at peak crop seasons, it naturally swamps ordinary community health facilities.

In the meantime also, existing workmen's compensation laws, providing financial awards to workers injured on their jobs, ought to be extended to cover agricultural workers (now generally excluded). Assistance from the cooperative Federal-State Vocational Rehabilitation program should also be broadly extended to correct physical or mental disabilities among farm people and put them in shape to do a better job. If a good Nation-wide health program should be developed, many of these special, piecemeal programs might not be so important, but until then farm people ought to have the greatest possible benefit from them.

One High Standard for All

Ideally every farmer and every farm worker should be able to contribute to a national health insurance fund. With the attainment of the goal of full employment we would come close to this ideal. For a time, however, contributions would probably have to be paid out of general govern-



ment revenue on behalf of needy groups in agriculture such as migratory farm workers or bare subsistence farmers. Regardless of the source of funds, the important thing is that the services these underprivileged people receive should be the same as for anyone else, and not under separate "welfare" arrangements as at present.

It is not good to see separate systems of medical service in a democracy, one for those who can afford to pay and another for those who cannot. We would like to see one good high-quality system of medical service for all people, regardless of just how it is financed.

Regarding this whole problem of payment for medical services, it is important to keep in mind that there is no conflict between the organization of voluntary county plans or State plans, as discussed above, and the possible enactment of a national health insurance law including farm people. As a matter of fact, the organization of a large number of county or district or State plans would not only indicate that people want something done about paying for medical care but it would also result in setting up administrative machinery for health insurance which would be immensely useful, whatever may happen.

CONSTRUCTING THE NEEDED HEALTH FACILITIES

If payment for medical and hospital and related services were assured, it would be all the more necessary to have the facilities in which to take care of people. At the same time, fortunately, it would be all the easier to get the needed hospitals constructed because their financial maintenance would then be guaranteed.

Where Is a Hospital Needed?

Now, what community actually needs a general hospital and what community is already supplied with the right number of general hospital beds? If more beds are needed, should they be in a new building or in an extension of an existing hospital? Are there obsolete hospital facilities that ought to be replaced? The answers to these questions, of course, depend on a lot of things, like the population to be served and its distribution, the age groups and the amount and kinds of sickness in a locality, the transportation facilities, the extent to which the local people are accustomed to using hospitals, and so on. Undoubtedly, with purchasing power available through some prepayment or health insurance plan a lot of people's habits in this connection would change.

It seems clear that, on the average, rural sections ought to have about 3.5 or 4.0 general hospital beds for every thousand people, even taking into account the advisability of referring certain serious cases to larger hospitals in the cities. Farm people should not be expected to be satisfied with only a half or a third of the hospital beds serving city people.

A State-Wide Hospital Plan

Now it is hard to say exactly when a ratio of 3.5 or 4.0 general hospital beds per thousand people is attained in a county or trade area. The people in your county might be served by a hospital in another county to some degree or some of the hospital beds in your county might be devoted to serving the people of the other county. Likewise, a fairly large city might be answering some of the hospital needs of the rural people in several counties around it. The only way to really be sure that all of the people in a State are served with enough hospital beds is to map out the entire State, showing the location of every general hospital and the number of beds in it. Then it may be roughly figured that each hospital should serve the population of the trade area within a radius of about 20 or 25 miles (up to 50 miles in a few sparsely settled western areas), though this naturally depends on roads and transportation facilities. A *master plan* can then be drawn up showing how many more beds are needed to provide the proper ratio for people within a certain hospital's range, or how many new hospitals of certain sizes must be constructed in places where there are no institutions now.

The Right Building in the Right Place

A community health committee, therefore, which is interested in getting a new hospital built or in enlarging an existing one, should first go to the State government, preferably the department of health, and propose that a master plan be drawn up for the whole State. Perhaps this is already being done in your State. A State hospital committee, representing the professional and hospital groups as well as the general public, might do this job. Then one can be sure that any new institution will be located in the right place for everybody concerned, and will provide the proper number of beds, clinics, and other facilities. Without such a plan, a lot of local enthusiasm might end up in putting a hospital in the wrong place or building it with too few or too many beds. A good master plan at the start will, in the end, save money and lives.

If, after consultation with the State authorities, everyone agrees that a hospital of, say, 100 beds ought to be built at Jonesville, then it is the job of the local health committee to go out and get support among the people for the idea. The big question, of course, is how to finance it.

Financing the Construction

The first thing that most of us think of is to get as many voluntary contributions as possible. This is all right except that in the rural communities needing hospitals most there is generally little

money to be given on a philanthropic basis. Therefore, it is generally a good idea to ask the county government to provide as much money as it can from its tax funds. The local government might raise money by issuing bonds for the purpose, or even by raising the tax rate. A hospital is, after all, a community service and should be financed out of community funds. The very "readiness" of a hospital to help victims of disease or injury is a public service, as much as the readiness of a police force to protect the public against other hazards.

If the average rural community, however, should limit its efforts at financing to just these local sources—private and public—there would actually be very few communities that could build the size and type of hospital that they need. The average modern general hospital is no small investment, costing nowadays around $5,000 per bed, everything included. A good rural hospital of 50 beds, for example, would cost about $250,000 to build and equip properly. Of course, large city institutions of several hundred beds may cost less per bed, but the necessity for fairly small-sized units in rural areas makes the cost per bed relatively high. If a good system of referral of special cases to larger city hospitals is worked out, the rural hospital can be quite simple and might cost less. Proper facilities, however, could probably never be furnished for less than $3,000 a bed.

Funds From Up the Line

The next step, therefore, is probably to explore the possibility of getting financial aid from the State government. If the Federal Government, moreover, should find it necessary to launch a public works program in the post-war period, the construction of hospitals and other health facilities would surely be an important type of project for such a program. Obtaining State or Federal aid or a combination of both will doubtless require a lot of detailed work, but the facts on this can probably be obtained by writing to the State department of health or to the United States Public Health Service. It would surely be best if such financial aid were to be forthcoming to rural States in proportion to their needs, with aid to local communities being extended by the States on a similar basis. This would be another practical use of the grant-in-aid mechanism, which has been applied so successfully to the support of general public health services.

Blueprints and Budgets

There are all kinds of technical problems in planning a hospital, involving everything from construction engineering to thermometers. Assistance on all these matters may be obtained from the State department of health or from the district office of the United States Public Health Service. For construction problems in particular, the Federal Works Agency could doubtless be helpful.

Community Sponsorship

If a hospital is to serve the best public interest, it should be operated by and for the entire community. It is best that it actually be owned by the county or township and that all qualified physicians be permitted to practice in it. In this way, some "free" beds can always be provided for those persons who may not be covered by some prepayment program and who cannot afford to purchase hospital service privately. In some areas, two or three neighboring counties might jointly operate a hospital, just as several counties might work together in a prepayment plan.

Another desirable type of community hospital is the kind operated by church groups or other non-profit associations. Care for the needy is often provided in such institutions through arrangements with welfare or public assistance agencies.

As we have noted, most rural hospitals today are unfortunately not operated on this community basis, but are privately managed, with few public or free beds and with the doors closed to certain perfectly well qualified local physicians. Of course, high medical standards should be maintained to assure the competence of every physician and surgeon on the staff, but staff positions should depend on ability, not ownership. The hospital has a teaching function, furthermore, for all the doctors in the area, helping to keep them abreast of the times.

A Regional Network of Hospitals

In all this planning, it should be realized that every rural community needn't be served by a hospital equipped to handle all the rare and difficult types of cases. It would probably be best for the average rural community to be served by an institution of, say, 50 to 75 beds, with good equipment for general surgery, for maternity service, and for the diagnosis and treatment of the most important diseases. Even smaller units to serve as "health centers," which will be discussed below, would be good in some thinly settled areas. Ideally, a few doctors' offices might be located right in the hospital.

A system should be promptly worked out for the referral of the more difficult and complex cases to larger institutions with more elaborate equipment and more highly trained staffs of specialists. Such a network of rural hospitals, feeding into larger central institutions—just as in the Army there are field hospitals and base hospitals—could best be worked out by the State hospital committee or by the State health department developing the master plan.

Ambulance Service

If this system is to work, good ambulance service would have to be readily available. It is needed also, of course, to bring patients to the hospital from outlying districts. This is especially true in the great stretches of the West. Even helicopters—planes that can take off and land on a small plot of ground—have been contemplated for areas where distances are great or roads are bad. At present, most ambulances in rural areas are run privately, and low-income families can seldom afford to use them. The best plan would be for the ambulance to be provided by the local government, probably through the health department, and put at the service of everyone.

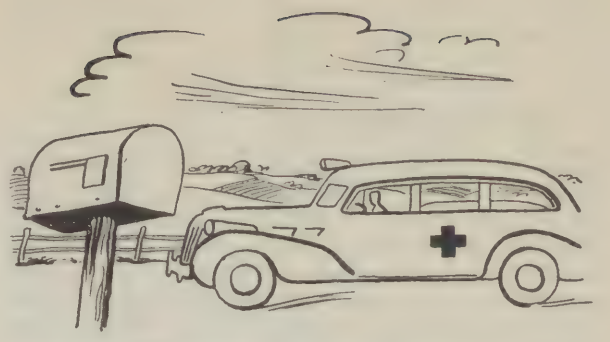
Beds for Tuberculosis and Mental Cases

For tuberculosis and for mental diseases, special provisions are necessary. Planning for the construction of the needed number of beds for these conditions certainly requires action by the State government. Institutions of this type should usually serve a dozen or more rural counties. The cost per bed of these institutions is generally lower than for general-hospital beds but it is important that enough money be appropriated from year to year to maintain them properly. In TB sanatoriums, it is especially important that enough beds be provided for colored people, since TB is much more common among them.

In many States the need for beds for tuberculosis and mental disorder is greater than for general beds. You can figure out the number of new beds needed for tuberculosis and mental disorder by reference to the ideal ratios of 2.5 tuberculosis beds for every tuberculosis death each year and 5 mental disease beds for every 1,000 in the population. Few people need die of tuberculosis in this day and age, nor should victims of mental disease suffer needlessly and go along without hope of recovery.

Beds for Chronically Diseased

Special hospitals for taking care of convalescent cases or of chronic diseases are also widely needed, especially with the higher proportion of our population nowadays reaching the older age groups, where chronic illness is most common. In rural areas, special sections of general hospitals can often best be devoted to the care of these cases.



Surplus Military Medical Supplies

One of the big problems in setting up a hospital is getting the necessary special equipment. On an average, the cost of equipping a new hospital runs about 15 percent of the total outlay—a big figure. With the war over, however, a tremendous stock of surplus military medical equipment and supplies will be available for civilian use. It has been estimated that the value of all this property exceeds $200,000,000. This amount would furnish more equipment than would be necessary to supply all the new rural hospitals that we need.

Group Purchasing

If rural communities and their institutions are to get the benefit of this surplus medical property, they have to take active steps to put their requests on record. The United States Public Health Service, which has district offices throughout the country, is playing a key roll in the distribution of all this medical property, acting under the direction of the Surplus Property Administration. The disposal of hospital and medical equipment and supplies could probably be carried out more effectively if those in charge of the overall disposal program could deal with a single medical purchasing association in each State rather than with scores of separate hospitals. Such an association might be set up to act for all the institutions in the State, now existing or to be built in the future.

For the time being, any community wishing to take advantage of surplus medical and hospital equipment should get in touch with their State health department to present proof of its need and to get help in determining the kind and amount of property it should have. From this source help can also be obtained to set up an organization that will be able to qualify as a purchaser under the Surplus Property Act. Surplus medical equipment and materials will likely be allocated communities and groups on the basis of need.

The availability of all this surplus property at relatively low cost might well serve as an inducement for rural communities to do something about establishing a hospital. At the same time, rural communities might use such equipment and supplies as inducements to physicians or dentists to set up practice there. Possibly they could pur-

chase the equipment and offer it free to the prospective practitioner or make it available to him along with free or low-cost office space.

The Health Center

There is another type of health-facility construction which, in a way, is even more important than the hospital. That's the health center—a building for the administration and provision of modern preventive and treatment services. At least one of these centers ought to serve every rural county in the United States. This is a less costly project than a general hospital and can be launched more readily.

Instead of being in the basement of the county courthouse, the health department ought to be housed in a modern sanitary building, in keeping with its important responsibilities. The health center should be located, if possible, in close relation to the main general hospital of the area. At the center there ought to be ample provision for the several clinics that are operated by a good department of health, especially clinics for maternal and infant hygiene, for venereal diseases and tuberculosis, for mental hygiene, and for dental care. Room should be provided for the offices of any private agencies which may be conducting health services in the county, such as the tuberculosis association, the visiting-nurses association, and the Red Cross.

Modern Diagnostic Equipment

Ideally, space should also be provided for the offices of practicing physicians and for special diagnostic equipment like an X-ray machine, an electrocardiograph, a basal-metabolism machine, clinical laboratory apparatus, and all the other technical devices of modern diagnosis and therapy which are so important but usually too expensive for any one rural doctor to maintain. These diagnostic facilities should be available to all the doctors in the area. Finally, the health center, if it is in an outlying district, should have a few "infirmary" or "auxiliary hospital" beds for handling maternity or accident cases and various other emergency cases before they are transferred to a general hospital.

Such a health center should cost no more than about $30,000 or $40,000. A modest center for a thinly settled area might be built for $10,000 or $20,000. If such health centers were available everywhere, we could be sure not only that better public health and medical services would be provided, but that rural people would be encouraged to pay more attention to the maintenance of their own health.

Mobile Clinics

For isolated and very sparsely settled rural areas it would probably be helpful to have different types of mobile clinics. This would apply particularly to a service like dental care, for which the need is practically ever-present; that is, whenever the clinic trailer came around there would probably be plenty of dental work to do. It would apply also to maternal and infant care, to immunization programs, and even to mental-hygiene work. Health departments could be asked to provide such mobile clinics, and the physician or dentist in charge could be paid his salary by the people served, through a prepayment plan, or else by the health department. Much of the surplus military equipment will be especially adaptable for use in this type of mobile medical program.

Community Sanitation

Finally, we must think of the construction of projects for better environmental sanitation. These are projects on which immediate action can readily be taken. The need for better public water supply and sewage-disposal facilities is actually greatest in the small communities of under 2,500 population. Projects for community water

supplies or sewers could probably be financed on the same grant-in-aid basis as hospitals. It is necessary that rural communities make accurate studies of their needs and submit them to the State department of health, with an analysis of their local financial resources. Highly important in some areas also are facilities for the pasteurization of milk. The marvelous new insecticide, DDT, should help greatly to rid our rural areas of malaria. Far too many people in the rural districts still get sick from diseases spread by polluted drinking water or unpasteurized milk or by mosquitoes and flies.

Farm and Home Sanitation

In the open country the construction of individual family-unit sanitary facilities is more difficult. Many folks say that it is mainly a question of a farmer's coming to realize that he ought to build himself a new sanitary privy or screen his house or drill a new well—or bring running water into the house and use a septic tank. More often, however, it is a question of finances. Still, there's no reason why a farm family shouldn't have the same household conveniences as city families.

The Sanitary District

One of the chief barriers to the improvement of sanitation in the open country has been the lack of a suitable organization of farm families by which sanitary programs could be promoted and financed on a group basis. A practical way around this, used in certain suburban areas, would be the organization of *sanitary districts* by a petition of property owners to the local government. If the petition is granted a district may be set up and incorporated very much like a drainage or irrigation district. Boundaries would be set and officers elected.

Any sanitary improvements decided on could then be submitted to a vote of the taxpayers in the district. Loans would be made to finance the work by floating bonds and would be repaid by assessments against the farm owners whose property has benefited by the improvement. Most important, the sanitary district would be in a position to obtain grants-in-aid from the State or Federal Government. This would, in effect, make funds available for the improvement of individual farms which would not be forthcoming to the farm owners as private individuals. Once facilities are constructed, the district would provide a splendid mechanism through which maintenance and repair services might be obtained. Some existing organization in the county might serve as the nucleus for organizing a sanitary district.

If your State doesn't now have a State law allowing the formation of such districts within the counties, you might want to look into the matter. In the meantime, we shouldn't put off making needed improvements until a law is passed, but we ought to realize how much more can be accomplished on this group basis than as individuals. State sanitary codes requiring adequate sanitary facilities in rural areas—facilities that would not involve a menace to health—would help a lot, too.

In regard to all these hospital, health center, and major sanitation projects, it is important to remember that all construction plans should be brought to the attention of the local and State health agencies, the district office of the U. S. Public Health Service, and probably also the regional office of the Federal Works Agency. The best way to be sure that a rural community will get the benefit of financial aid from the Federal or State Government is for the rural people themselves to demonstrate that they want a particular health facility.

GETTING MORE DOCTORS, DENTISTS AND NURSES FOR THE RURAL AREAS

As we have seen, the most fundamental way to assure enough doctors and dentists and other personnel in the rural areas would be to guarantee them good incomes and the provision of necessary scientific facilities. While these purposes may ultimately be accomplished through prepayment or social security plans and through grant-in-aid programs for construction, several other steps can be taken by rural communities to assure themselves of more practitioners, without having to wait until these programs exert their full effect. As a matter of fact, one of the first things that a health-conscious group of farm people often wants to do is to "recruit" some more doctors for their community right away. How can they go about this?

National Procurement and Assignment

We have already noted that, growing out of the wartime needs for mobilizing the armed forces, a kind of manpower agency for professional people was set up in the War Manpower Commission, the National Procurement and Assignment Service for Physicians, Dentists, Veterinarians, and Nurses. Some propose that such an agency should function in the demobilization period for the special job of trying to distribute America's medical and dental veterans in areas according to need. It would not have to conduct any compulsory program, but could provide a free flow of information as to where physicians or dentists were badly needed and where they could still make a successful living. The agency might pay the expense of moving to the place of new settlement and could help finance the cost of setting up the doctor's office.

When "Doc" Comes Marching Home

Even if such organized national action is not taken, there are several things that might be done at the State level or in the counties. This demobilization period after a long war presents an opportunity to rural communities that may never come again. With the tens of thousands of doctors and dentists and nurses being released from the armed forces now that victory is won, there is a definite possibility for rural communities

to get the professional people they need, if they make an appeal.

The State procurement and assignment service, the State department of health, and the United States Public Health Service would be happy to receive such appeals. As a matter of fact, if appeals are not made, the chances are that the great majority of veteran doctors, as well as new graduates, will settle in the big cities, where money and facilities seem more plentiful.

Come on to Our Town

A rural community, then, could offer a practitioner an attractive house in which to live and an office in which to work. This means a lot to a doctor and his family. The office might best be in a hospital or a health center. The community could offer to provide him with technical equipment from war surpluses, as suggested above. It could pay his traveling expenses to get there and the cost of moving his family and household effects. It could even guarantee him a certain minimum income for the first year (such as $4,000 or $5,000) by agreeing to make up, from county tax funds, any amount by which his income from private practice might fall short of the guaranteed sum. If a prepayment plan were operating, the chances are that no county funds would have to be used. A rural community could advertise offers such as these in the medical journals of the State medical association or the American Medical Association, or the corresponding publications of the dental profession. It could pass these offers on also to the State and National Procurement and Assignment Services. These are other jobs for a community health committee to do.

Rural Medical Fellowships

If there is a medical school in your State or one nearby, it might be asked to provide rural medical fellowships—that is, to arrange for the education of a number of medical students on the understanding that they would set up practice in a rural community and remain there for 5 years or so. First preference should be given to rural youth, who naturally like the country best and would be more likely to remain in practice there for good. Medical education is quite expensive nowadays and very few rural families can afford to send their boy—or girl—through medical school. The funds for such rural medical fellowships might be provided by the State or even occasionally by a county government. There could be "rural dental fellowships" too. Special attention should be given to the need for training more Negro physicians and dentists, as well as nurses, particularly for the rural South.

Medical Schools in Rural Regions

If there isn't a medical school in your State, possibly one ought to be started. Or perhaps there is a small school that ought to be enlarged or a 2-year school that ought to be made into a full-length 4-year school. More physicians and dentists have to be trained anyway if all rural and urban needs are to be met. One of the best ways to assure the settlement of physicians and dentists in rural sections is to select medical and dental students from the country in the first place. First-rate medical schools in all the principal rural regions—located, of course, in an urban center—would encourage such selections. Furthermore, a good medical school acts as a center of learning and medical counsel for the physicians of the entire region. This is a subject in which your State government might be interested.

Professional Licensure Laws

Another problem faced by most rural States is the existence of outdated professional licensure laws which act as Chinese Wall barriers, keeping out physicians and dentists from many other States. It is true, of course, that many States have "reciprocity" with other States; that is, their boards of medical licensure admit doctors from certain other States without a written examination (which tends to be so detailed that a physician several years out of school usually hesitates even to take it). Such licensure reciprocity could be extended much more fully among the States. Better yet would probably be nationally uniform licensure laws which would guarantee well-qualified medical and dental graduates for all States in the Nation. The National Board of Medical Examiners is already a step in this direction.

Trained Nurses

Trained nurses can be attracted to rural areas by having an adequate supply of physicians and modern hospital facilities. In addition, student nurses might be added to the staffs of rural hospitals for part of their training, by arrangements with the nursing schools in the larger cities. This experience, furthermore, might attract the nurses to the country on their graduation.

An increase also in the number of public health nurses and medical social workers is sorely needed in most rural communities. These health workers, by going out and detecting cases requiring medical attention or educating people on sound personal and environmental hygiene, extend the arm of the physician into the homes of rural people and save his time. They can help see that treatment prescribed by the doctor is carried out in the home.

Professional Aides

Fuller use of all kinds of auxiliary personnel could save the doctor's time in other ways. Many tasks now consuming the time of rural physicians or dentists could well be done by professional aides, working under supervision. Refractions for eyeglasses, for example, can be assigned to

optometrists, and the care of certain conditions of the feet can be handled by chiropodists. Many other special functions can be performed by laboratory technicians as well as by physiotherapists, clinic aides, dental hygienists, and others. Administrative, financial, or clerical work can be done by special lay workers who do not require the extensive technical training of the physician.

There may not be much that a community health committee can do directly to obtain medical aides of this type, but it could promote the organization of clinics or plans which would make use of this type of auxiliary personnel and put teamwork into medical service.

EXTENDING PREVENTIVE HEALTH SERVICES AND HEALTH EDUCATION

While sickness obviously must be treated when it occurs, it surely makes better sense to prevent it before it starts.

Good Living Is Basic

The best way to prevent disease is to be sure that everyone has a good education and an adequate income so that he can have decent housing, a well-balanced diet, and enough rest and recreation. Of course, the early diagnosis and prompt treatment of disease is good preventive medicine, too, by preventing slight illnesses from becoming serious. Beyond this, however, there are many specific preventive activities which can be carried out by a good department of public health.

Arming Against Disease

The health department can help to provide for better environmental sanitation and prevent the occurrence of filth-borne diseases. It can teach the essentials of good nutrition, raising the resistance of the individual against many ailments. It can provide special care for expectant mothers and new-born infants and thereby prevent disease or death among mothers and children. It can help teach school children sound hygiene practices and keep them in good health. It can promote good dental habits in children and adults. It can prevent the spread of devastation of the venereal diseases and of tuberculosis. It can give immunizations and prevent epidemics from acute communicable diseases. It can do much to prevent serious mental disorders and insanity by setting up mental-hygiene clinics and educating people about mental hospitals as places of treatment rather than incarceration.

Health Education

The health department can provide health education on malaria and typhus and cancer and heart trouble and can help rural people to become more health conscious and take better care of themselves. In many rural areas, as we have noted, there is a particularly heavy burden of preventable diseases like hookworm infestation, typhoid fever, or malaria, so that special public health measures are necessary to eliminate these scourges. Every rural section has its own special problems which ought to be attacked by a health department.

An Adequate Staff

Before all these things can be done, of course, it is necessary that the area be served by a well-trained and adequately paid public health staff headed by a good health officer. On the staff there should not only be plenty of public health nurses (at least 1 for every 5,000 of the population, preferably 1 for every 2,000) and sanitarians (at least 1 for every 10,000 or 15,000 people), but ideally there should also be experts in sanitary engineering, health education, nutrition, laboratory work, and vital statistics, as well as clerical and maintenance personnel. Attached to the staff, too, should be public health dentists and special clinic physicians. Technical consultants should be freely available from the State department of health.

Public Health Districts

To support a competent local staff, however, greater financial resources are required than are available in most rural counties with a small and relatively low income farm population. A plan has been proposed to get around this difficulty. The American Public Health Association has recently suggested that counties with small popula-

tions and the towns in them group together to make up *districts* of at least 50,000 people. This is probably the smallest number of rural people that could financially support a unit of the necessary size and competence. If several counties are to be grouped in such a district, the distance from the headquarters to the farthest point should not exceed about 40 miles.

Most of the State health departments have already agreed to this plan and a few have long followed it in principle. It has been found, on this basis, that the 3,070 counties in the Nation can be grouped into fewer than 1,200 districts. The districts in rural sections would usually consist of two or three or four counties. A community or county health committee could inform the State health department that it would be ready and willing to see its county cooperate with one or more neighboring counties in the organization of an effective district. This means pooling of funds and pooling of interests for the betterment of all the rural people in the area.

County Dollars

Of course, all of the organization in the world won't do any good if there isn't money on hand to do the job. The real reason why most health departments have been very weak has been that not enough State and local funds have been appropriated for their support. The national average for all public health expenditures has been at the rate of only about $1 per person per year, and in rural areas it has been much less. Yet to do even a minimum job of preventive health services, about $2 per person per year would be necessary for the average rural section, and some sections would require more than this.

In many rural counties, a fixed limit on the amount of tax funds that may be spent for public health is prescribed by law. With these limitations little health progress can be expected, except through changes in law or contributions from outside sources like the State and Federal Governments. Yet if the health needs of an area are to be satisfactorily met, the local government will need to support adequately the costs of its program. If rural communities would put up about a dollar per person per year themselves, with another dollar or more coming from outside sources, a great deal more could be done to prevent disease than we have ever seen.

An Ounce of Prevention

Compared with the annual expenditure of approximately $30 per person made for all medical and related services, it would not seem much to expect a local outlay of $1 per person for prevention. Certainly if the officials of the county government were made aware of the fact that, as a wise man once said, "health is purchasable," they would try to appropriate more funds for it. Once a local community has shown that it is willing to spend money on public health services, it is in a much better position to get the benefit of grant-in-aid funds provided by the States and Federal Government. Undoubtedly when more local initiative is shown in organizing public health services, more Federal funds will be appropriated to match local and State expenditures.

State Public Health Legislation

Most States now have what is called "permissive" legislation regarding the setting up of local departments of health. This means simply that a county or a community *may* appropriate funds for public health services if it wants to. What may be needed, however, is mandatory legislation in which every community or, as we have been suggesting, every health district (including at least 50,000 people, in accordance with a State plan) would be *required* to organize a health department and appropriate funds for it. This sort of law, for example, governs the establishment of public schools by the counties. Some folks may disagree, but this would be the surest way of having public health services cover every rural citizen, without waiting till after more thousands of preventable deaths have occurred. At the same time, State funds should be appropriated to make any mandatory law effective, especially to help areas that are too poor to have an adequate source of revenue by themselves.

School Health Programs

The schools can do much for the health protection of our children. They can conduct health examinations and perform immunizations. They can offer hot lunches at noontime and give instruction in nutrition. In fact, they have a greater opportunity, over the years, to teach sound habits of health and hygiene to the Nation's future citizens than any other institution in our society. Schools need also to direct their teaching toward helping grown-ups recognize the advantages of being healthy people in a healthy community.

Voluntary Health Agencies

Of course, other agencies carrying on special health programs should be utilized to the full. Extension agents in home economics have spread health knowledge among rural homemakers and youth, particularly on the relation of food to health. The Red Cross, the Tuberculosis Association, and service groups like the Rotary, Lions or Kiwanis Clubs have promoted a great deal of good, practical health education. Where there is a local visiting-nurses association, it can naturally render a great deal of nursing service at bedsides in the farm homes. All of these agencies have done a worthwhile job, but a great deal more can be done along these lines for farm people.

Safety First

Accidents and fires cause so much death and disability among rural people that some safety-

promotion program deserves a place in every community. Many agencies can spread the word on proper precautions to prevent fires and accidents. Every farmer should be encouraged to check his place in detail at least once a year to detect hazards and eliminate them. Courses in first aid should be taught.

Unified Administration

If all the various activities concerning public health and medical services, preventive and curative, are ever to be organized properly, there ought to be one agency in every local area really in charge. After all, it does not make sense for hospitalization to be handled by one group, venereal disease control by another, school hygiene by another, visiting nurses' services by still another, various health insurance plans by other groups, medical care to welfare clients by others, laboratory tests by others, and so on. It's all pretty confusing to the public and a lot more expensive this way. Although many agencies may play some part, it would seem far wiser for all the organized health measures to be supervised by one over-all health agency in every local area.

The health department, with its history of public trust and its technical abilities, would seem to be the logical agency to carry on this job. It is true that there was a time when health departments were reluctant to go beyond watching out for epidemics and sanitation. This is certainly changing, however, and people are beginning to realize the importance of broad government responsibilities for health. The construction of many-purpose health centers will facilitate this end.

It should be recognized that all this applies to the administration of health insurance programs. If health insurance is launched on a State-wide basis or if it is made a national law of the land, its actual administration should be carried out locally to the greatest extent possible and there would be need for some local agency to handle the job. The supervision of this work through the local health department would probably be the best practice.

Health-Service Trade Areas

There has been a good deal of talk about mapping out special districts for hospitalization, for physicians' services, for public health services, and so on. The important thing to remember is that if one set of district lines is mapped out for one type of health service and a different set of district lines for another a lot of confusion will result. It should certainly be possible to work out a district pattern for public health services which can be applied also to hospitalization, to physicians' and dentists' care, and all the rest.

It would undoubtedly be best if the boundaries of such districts were to follow the natural trade-area patterns by which rural communities carry

on their business, rather than strict county lines. For example, the farmers at the edge of one county might customarily go to town in the next county to do their buying and selling; in such a case, a health district with headquarters in this trade center ought to cover these farmers in the neighboring county. This kind of organization can be accomplished if county government officials are truly concerned about the welfare of their people.

IMPROVING THE QUALITY OF RURAL MEDICAL SERVICES

If all of the foregoing steps could be taken in your community, a great deal would be accomplished in elevating the actual scientific quality of the medical services that rural people receive. Nevertheless, without further steps being taken, the quality of rural service would still tend to remain poorer than that of the cities.

New Medical Developments

As things are now it takes much longer for a new scientific development to be put into practice in an isolated rural area than in a big city. The war has brought out many new medical discoveries and new practices which can benefit mankind. A few are: Penicillin for several infectious diseases, DDT for eliminating certain insects, new ways of using blood and plasma, new methods in surgery and psychiatry and other fields. Rural doctors, through no fault of their own, easily get into a "rut" and fail to give their patients the benefits of these new developments in medical science.

Postgraduate Education

It is to the interest of rural people themselves, therefore, to help their doctors get ample opportunity for postgraduate courses in medicine and surgery. The medical school in the State or in a nearby State could be urged to offer or expand such courses, and the way could be made

easy for local practitioners to attend them. Possibly State funds could be provided to pay physicians or other professional people stipends or scholarships while they are taking these studies for, perhaps, 2 or 3 weeks every year or two. Much good could also be accomplished by having leading physicians in the State spend a few days with the doctors on the staffs of rural hospitals. The State health department and the medical school might sponsor this jointly.

The important thing is that all possible means should be used to assure that medical men keep up with the rapid strides of medical science. Through licensure requirements, postgraduate studies, perhaps periodic relicensure based on such studies and possible reexamination, and fellowships to make this possible, much could be accomplished toward raising the standards of rural practice.

Specialists and Group Practice

Even if the country practitioner were to be kept constantly abreast of the times, the field of medical science has become so big that he couldn't be expected to master it all. No one doctor working alone can practice modern medicine in the sense of being able to handle properly all the cases that come under his care. Specialization is absolutely necessary for good medical service. Many physicians have even proposed that licenses be granted in the several special fields of medicine and surgery, so that if you had to have your appendix out you could be sure of having it done by a qualified surgeon, or if you had to get eyeglasses you could be sure of having a qualified eye doctor.

Yet specialists can hardly be expected to set up individual practice in the average rural area. To make a go of it, they require referrals of cases from other physicians who all together are handling thousands of patients. One way to make the services of specialists available to rural people would be to organize more group-practice clinics in rural sections, as has been done to a greater extent in cities. Many economies are effected in such clinics. They can save the patient money and save him time, as well as putting teamwork into medical practice. Most important, they make for a higher quality of medical service.

A Battery of Experts

In a group clinic there might be two or three general practitioners, a surgeon, a pediatrician (child specialist), a specialist in obstetrics and diseases of women, and possibly a specialist in diseases of the eyes, ears, nose, and throat. A dentist or two might also be part of the group. A larger group might include also a psychiatrist, a radiologist (X-ray specialist), a skin specialist, and perhaps a urologist (kidney specialist) or other specialists. Nurses, clinic aides, and technicians would be part of the staff. The patient would be seen first by the general practitioner and then referred, if necessary, to one of the specialists. While the great majority of day-to-day illnesses can be fairly well handled by the general practitioner, it is the few complicated ailments that constitute the greatest hazard to life or limb, and it is these that call for the services of a specialist.

Group Clinics in Health Centers

In a small rural community with a few thousand people, such a group clinic could probably not be financially supported, but if it were organized in a health center serving 50,000 people or more, or in a subcenter serving 15,000 or 20,000, it could make a go of it and provide a great deal of high-quality medical service. The provision of modern equipment and offices in health centers could stimulate doctors to organize these group clinics. A prepayment plan, moreover, could be used to provide financial support. One of the reasons that our boys in the armed services are getting such good medical care, and that better than 95 percent of the battle casualties have been saved, is that the Medical Corps of the Army and Navy are really organized along group practice lines much like that described here.

Even if a large number of group clinics were organized and if postgraduate education were systematically carried on, there would still be need for referrals of difficult cases among rural people to larger urban centers. The network of interrelated hospitals necessary for smooth channels of referral, which we have discussed, would still be needed to assure the best service to rural people.

Medical Research

Finally, we must not forget that a higher quality of medical service in rural and urban areas alike depends on advances in our knowledge about disease, which can only be made through energetic research. Even though, in the present state of rural medical practice, there are many known facts which are not being generally applied, there are undoubtedly many more facts which have not as yet been discovered.

The centers of medical research should, of course, remain in the large cities, but the opportunities for research should be open to rural prac-

titioners as well as urban. The ideas born in a village should have the same chance for development, through detailed experiments, as ideas born in a great city laboratory. If your local doctor has some new idea concerning which he wants to experiment, he should be encouraged to do so. The health department and the local hospital also should be encouraged to carry on appropriate research activities. Such research serves not only to advance our knowledge but provides stimulation that keeps up the day-to-day level of medical performance.

HEALTH SECURITY FOR FARMERS—A JOB FOR MANY HANDS

No one group of farm people can do all of the things discussed in this publication. Attaining a parity of health services for rural America requires action from many different levels. It requires action from the Federal Government, from State governments, and from local governments. It requires action from professional societies and organizations of all types. But most of all, it requires action from the rural people themselves.

The problem as it is and some of the steps that might be taken to solve it have been considered. Practically everything recommended for the future is based on the experience of the present and the past. In other words, by sifting our knowledge from all sources, we find the solution to health problems emerging right out of accumulated experience.

Plans Are the Thing

One thing that stands out in every aspect of the problem, above all, is the need for *planning*. The health problem will not solve itself unless all of us do a lot of thinking about it. All the planning cannot be done solely in the counties. There must be planning also by the State governments and by the Federal Government, if all sections of the country are to be provided with the same high quality service. The planning in the counties should, therefore, be done within a framework of State and Federal action which may be reasonably expected.

The final delivery of health services must be a State and local responsibility, but the solution of the fundamental economic problems involved requires the pooling of the resources of the whole Nation, which can only be done through national action.

Rural Health, a Special Problem

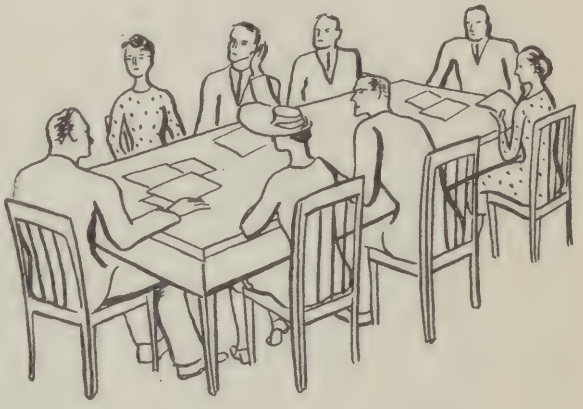
Our Government has come to realize that the health of rural people is a special problem, requiring special attention if it is to be solved. The big cities, in a sense, can largely take care of themselves, but the rural areas, because of the problems of geography, economics, and education require special methods of organization. Some have suggested that a special agency of rural health services might be set up in the Federal Government, to help coordinate and strengthen all the different measures required to conquer rural disease.

And yet we should not fall into the error of thinking that agriculture or the rural areas should work out a program of health services entirely separate from that of the cities. If this were done, the quality of rural services might always tend to be lower than the quality of urban services, in proportion to the lesser wealth in the rural areas. On the contrary, the provision of a parity of health for the farmer is part and parcel of the whole problem of organizing good health services for the entire Nation.

By taking positive steps to improve their health services, furthermore, the farm community is actually helping to develop a good health program for the whole Nation. The best way to be sure that the needed action will be undertaken is for farm communities to demonstrate that they are interested sufficiently in the health problem to set out and tackle it themselves.

Let's Talk It Over

All people certainly want better health services, but many of them do not know how to go about getting them. The immediate job is to bring out all the facts. Community health committees, as discussed here, can study these facts and start the ball rolling. Local doctors, public health officials, and others will be glad to provide technical advice.



A conference might be called of all the farm organizations and other groups interested in rural welfare in your county, or your section of the State, or even in your entire State. Together, all can decide exactly what should be done—what steps should come first in your particular State or

county. Permanent committees can be set up to follow through.

Better Health for Rural America

Great opportunities for the achievement of better health for rural America lie before us in the years following the war. Health insurance for all rural people—removing the cash barrier to medical service—is within reach. Hospitals and health centers can be built in a great construction program. Thousands of doctors and dentists will be demobilized and can be attracted to settle in rural sections. Public health agencies can be strengthened everywhere. Twentieth-century medical science can be brought within the reach of every farmhouse and every village.

All these things are possibilities, but it remains for rural people themselves to make them into realities. They must get at the facts, study them, and plan wisely. They must organize their communities to tackle their health problems. Working with other communities—both rural and urban—they must move steadily toward the solution of every problem they face. When these things are done we can be sure that rural people everywhere will attain the parity of health services that they deserve.

NOTES ON OUR COMMUNITY

What are the facts about health conditions?

NOTES

What are the facts about doctors, hospitals, etc?

NOTES

What is being done now to solve our health problems?

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